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Senior healthcare managers' perspectives on using social media patient feedback to improve care

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(iv) Abstract

Background

The Patients' Rights Act (Scotland) 2018 requires that Health Boards in Scotland encourage, monitor and learn from patient feedback. A range of mechanisms are used by healthcare organisations to capture and monitor the quality of care and services they provide, and to stimulate improvement where required. Historically these have been a mix of paper-based methods and face-to-face mechanisms. In recent years these traditional methods are increasingly being augmented by spontaneous sharing through social networking tools like Facebook and Twitter, and through dedicated patient feedback websites like Care Opinion. There is little published evidence regarding the legitimacy of capturing and interpreting patient feedback using social media. This research explores senior healthcare managers' attitudes to and acceptance of online patient feedback, and its potential to inform improvements to health and care services. It considers the suitability of social media for monitoring patient experience and considers the main barriers to using this information to inform changes to healthcare services.

Interviews were conducted with 18 senior clinical and managerial staff from three National Health Service (NHS) Boards in Scotland in order to build an in-depth understanding of their attitudes and experiences regarding the use of social media patient feedback for improvement to health and care services. A process of Framework Analysis was used to identify the key issues, concepts and themes expressed by interview participants.

The results of this study show contrasting views on the usefulness and value of patient feedback. Participants highlighted the importance of understanding and accepting the patient perspective on their healthcare experience, whilst others questioned patients' ability to judge the quality of their own care. The emotional impact of both positive and negative patient feedback on healthcare professionals was a key issue for participants. The findings from this study show that senior healthcare managers' views on the legitimacy of patient feedback through social

media are influenced by a number of factors, these include apprehension around the anonymous nature of social media patient feedback; the impact of age and IT skills; the risk to organisational and professional reputation: and concern about the loss of face-to-face communication with patients.

The findings from this research study have a number of implications for the development of healthcare policy regarding patient feedback and experience, as well as for healthcare organisations in trying to maximise the benefit and impact of this information.

1. Introduction

1.1 Background

Patient experience is considered by many as one of the three pillars of quality in healthcare, along with clinical effectiveness and patient safety (Campbell et al. 2000; Doyle et al. 2013; Duschinsky & Paddison 2018). Patients are the common link between the multitude of treatments, appointments and hospital stays that make up the healthcare experience. As such, they are uniquely placed and motivated to contribute to improving the quality of their own care (Ward & Armitage 2012). In his review of the quality of care in NHS England Lord Darzi said, "If quality is to be at the heart of everything we do, it must be understood from the perspective of patients" (Department of Health & Darzi 2008). Such aspirations require a greater focus on how healthcare organisations and professionals collect, analyse and use patient feedback in quality improvement initiatives to realise these expectations.

Measuring patient experience is important not only to guide service improvement, but also because experiences of care are shown to be linked to clinical outcomes. Patients who have a positive experience of healthcare are more likely to trust their clinicians (Keating et al. 2002), more likely to follow treatment recommendations (Haynes et al. 2002, Doyle et al 2013, Chiou et al 2019), and less likely to die following a major clinical event (Glickman et al. 2010). There is also evidence of a positive association between patient experience and reduced healthcare costs and staff experience (Charmel & Frampton 2008; Bertakis & Azari 2011; Richter & Muhlestein 2017). A systematic review of evidence by Doyle et al. (2013) indicates consistent positive associations between patient experience, patient safety and clinical effectiveness for a wide range of disease areas, settings, outcome measures and study designs. For example, Isaac et al. (2010) found positive associations between ratings of patient experience and six patient-safety indicators (decubitus ulcer; failure to rescue; infections due to medical care; postoperative haemorrhage, respiratory failure, pulmonary embolism and sepsis).

A range of mechanisms are used by healthcare organisations to capture and monitor the quality of care and services they provide, and to stimulate improvement where required. Historically these have been a mix of paper-based methods (surveys, questionnaires, comment cards, complaints) and face-to-face mechanisms (interviews, focus groups, patient panels) (Ziebland 2013; Edwards et al. 2015; Sheard et al. 2019). In recent years these traditional methods for capturing patient feedback are increasingly being augmented by views conveyed through social networking tools like Facebook and Twitter (Gibbons & Greaves 2018; Griffiths & Leaver 2018; Marsh et al. 2019), and through dedicated patient feedback websites like Care Opinion (Baines et al. 2018; Atherton et al. 2019). The timely collection, interpretation and analysis of this patient feedback is essential to healthcare organisations in developing their understanding of what is working well, what needs to be improved and how they might go about it. However, there is little published evidence regarding the legitimacy of capturing and interpreting patient views that are not purposively solicited. This research explores senior healthcare managers' attitudes to and acceptance of online patient feedback, and its potential to inform improvements to health and care services. It considers the suitability of social media for monitoring patient experience and considers the main barriers to using this information to inform changes to healthcare services.

1.2 Public Inquiries into Failings in the Quality of Healthcare Services

An array of high profile publications about the quality of healthcare in the UK has served to heighten public awareness, and shine the media spotlight on patient safety and patient experience. A recurring theme in all of these publications is the failure to listen to patients and an inability to act promptly on their feedback to improve healthcare services. As early as 2001 the Kennedy Report into children's heart surgery at the Bristol Royal Infirmary made the observation "It is vital that healthcare services routinely seek direct feedback from patients. This is not something to be

feared but to be embraced." Twelve years later a public inquiry led by Robert Francis QC was established by the UK Government to examine why poor care and high mortality rates amongst patients at Mid-Staffordshire NHS Foundation Trust were not acted on sooner by the various responsible organisations. Francis concluded that this was primarily caused by "a serious failure of the part of the Trust Board to sufficiently listen to its patients." In an all too similar echo of the Francis Inquiry, the Kirkup inquiry (Kirkup 2015) into unnecessary deaths in the maternity unit at the Morecambe Bay NHS Trust in 2015 found that failure to hear from patients was an underlying cause of repeated errors.

The reports from these national inquiries also made recommendations around the need to improve the timeliness of the patient feedback. In his landmark report, Francis (2013) recommended that "results and analysis of patient feedback, including qualitative information, needs to be made available to all stakeholders in as near 'real time' as possible". Likewise a report by Department of Health Medical Director Sir Bruce Keogh (Bruce & Kbe 2013) into the quality of care and treatment provided by NHS Trusts in England stated that "real-time patient feedback and comment must become a normal part of provider organisations' customer service". Furthermore in his report 'A promise to learn – a commitment to act: Improving the safety of patients in England' Berwick (2013) stated that "patient feedback is instrumental to the measurement, maintenance and monitoring of safety; feedback should be collected as far as possible in real time and be responded to as quickly as possible".

1.3 Legislation and Policy Context

The requirement for healthcare organisations in Scotland, England and Wales to collect and act on patient feedback is enshrined in legislation. The Patients Rights Act (Scotland) 2018 provides a right for all patients to give feedback (both positive and negative) or raise concerns or complaints about the healthcare they have received. Importantly, the Act also requires that Health Boards in Scotland encourage, monitor and learn from the feedback and complaints they receive.

Supporting guidance entitled *'Can I Help You?'* (Scottish Government 2012) recognises that feedback, comments and concerns may be given to any member of staff and that it is therefore important that all frontline staff are trained to welcome and encourage feedback, comments and concerns from patients, carers and families.

In England and Wales the Health and Social Care Act 2012 (The Stationery Office (TSO) 2012) places a legal duty on healthcare organisations to seek feedback on the quality of services and to use this information for assessing, monitoring and improving the quality and safety of the services. The NHS Constitution (Department of Health 2015) sets out the guiding principles that govern the way that the NHS in England operates. A key principle in this constitution states, "The NHS will actively encourage feedback from the public, patients and staff, welcome it and use it to improve its services."

1.4 Using Patient Feedback for Improvement

As discussed earlier, the Patients' Rights Act in Scotland (Scottish Government 2011) requires Healthcare organisations not only to encourage feedback from patients but also to show they are learning from this "with a view to improving the performance of its functions". However simply stating they are listening is not enough; healthcare organisations need to understand feedback, interpret it and most importantly act upon what it is telling them (Coulter et al. 2014). A review of the English National Inpatient Survey determined that "simply providing hospitals with patient feedback does not automatically have a positive effect on quality standards" (DeCourcy et al. 2012). Churchill & Evans (2013) state that feedback cannot be reduced to a single metric to judge performance but it can be used to drive improvement. That drive is especially powerful locally; where board members and senior managers can see what the local community is really feeling about their service (Mercer et al. 2007; Lee et al. 2016). Regrettably, this is not always the case in the NHS, despite evidence that they can provide valuable insights into the care they receive, patients remain an underused resource in efforts to improve quality and safety in healthcare (Kroening et al. 2015). Rozenblum et al. (2013) argue that there is now an increasing gap between senior management and frontline healthcare professionals, with the former

providing little structure in how the latter can act on feedback to improve patient experience. A number of published studies highlight the local, regional and national work undertaken by hospitals, health boards and government to capture patient feedback (Powell et al. 2009; Reeves et al. 2013). Much of the research to date examining the influence of patient feedback has concentrated on the data collection methods or clinicians' views on the feedback. There is little evidence as to how this information is actively used to inform quality and safety activities. This disproportionate focus on surveys, questionnaires and measures may have "contributed to a tick box or compliance mentality" providing false reassurance for senior management that they were paying attention to patient experience (Robert & Cornwell 2013). Coulter et al. (2014) believe it is unethical to ask patients to provide feedback if little or nothing is done to act upon it and it is demoralising for those healthcare staff trying to make changes to improve patient care but thwarted and hindered in the process of doing so.

Simply giving staff feedback from their patients does not automatically have a positive effect on quality and safety of care (DeCourcy et al. 2012). Whilst there may be an ethical imperative to pay attention to and listen to the patient voice, this alone does not instil the necessary in-situ conditions for improvement to happen (Sheard et al. 2017). There are several reasons why healthcare staff might find it difficult to act on patient feedback in order to make improvements, including a lack of understanding around how the feedback is collected and analysed; the scepticism or mistrust about the relevance of patient feedback to their practice; a defensive reaction from staff to feedback that is perceived as critical; delays between data collection and feedback causing staff to argue that the feedback is out of date; or simply a lack of interest (Draper et al. 2001; Wilcock et al. 2003; Davies & Cleary 2005; Reeves & Seccombe 2008; Davies et al. 2011; Asprey et al. 2013). Anticipating and understanding these potential barriers may help senior healthcare managers plan to minimise them and to increase responsiveness.

Whilst there is an increasing evidence base to show that patients can give valuable insights to help increase the quality of healthcare, organisations continue to find it

hard to respond to what patients are saying (Sibley 2018). There is little published research available to show that this intelligence is regularly and systematically used by healthcare organisations to make improvements to care and services. This is in part due to a disproportionate focus on collecting the feedback from patients rather than how organisations can learn from feedback and create the right conditions for staff to make improvements. There is enthusiasm from many staff around capturing the patient's eye view of service quality, whilst others remain resolutely sceptical about the validity and objectiveness of this information.

1.5 Research Question

This research study sought to address the following question:

What are senior healthcare managers' perspectives of using social media patient feedback to improve care?

1.5.1 Definition of key terms

Improvement

Patient feedback may be used to inform 'improvement' to care and services by increasing the responsiveness of healthcare organisations and professionals to the needs of patients and identifying potential areas of poor performance which might benefit from change (Fung et al. 2008; Contandriopoulos et al. 2014; Craig 2018). Service improvements in healthcare can improve provision, make cost savings, re-design services and reduce clinical errors.

Social Media

Social media exists in many forms. Blogs, social networking sites, content communities and virtual social worlds can all be classified as types of social media applications. This layer of platforms influences interaction at an individual, community and societal level, with the worlds of online and offline increasingly overlapping. Kaplan & Haenlein (2010) define social media as "a group of Internet-based applications that build on the ideological and technological foundations of Web 2.0, and that allow the creation and exchange of User Generated Content". This definition doesn't really capture the unique value proposition of these new technologies i.e. mass collaboration. Social media is collaborative and participatory by its very nature as it is defined by social interaction. It provides the ability for users to connect with each other and form communities to socialise, share information, or to achieve a common goal or interest. Tuten & Solomon (2013) characterise social media as "an online means of communication, conveyance, collaboration and cultivation among interconnected and interdependent networks of people, communities and organisations enhanced by technological capabilities and mobility". Howard & Parks (2012) concisely capture the different elements of social media in their definition (i) the information infrastructure and tools used to produce and distribute content; (ii) the content that takes the digital form of personal messages, news, ideas, and cultural products; and (iii) the people, organisations, and industries that produce and consume digital content. A common thread running through all these definitions of social media is a blending of technology and social interaction for the co-creation of value.

Patient Experience

There is no one consistent definition of patient experience in the research. Some researchers focus on the fulfilment of patient expectations (Bowling et al. 2013;

Tahir et al. 2012; Mekonnen & Enquselassie 2016), whereas other definitions have focused more on patient centred care principles (Weiss & Tyink 2009). Looking across the published research the most consistent concepts of patient experience include: acknowledging the individual expectations and needs of the patient, understanding both the emotional and physical elements of experience, and recognising the importance of partnership/patient involvement. A detailed exploration of the concept of patient experience is included in the 'Patient Experience and Feedback Chapter'.

1.6 Structure of the Thesis

This thesis is presented in 4 chapters that describe the process and progress of the study. Rather than include a separate literature chapter for my thesis I have undertaken an evaluative critical review and analysis of the relevant research literature and located the relevant parts within the 'Patient Experience and Feedback' and the 'Using Social Media as Patient Feedback' chapters.

1.6.1 Methods

Semi-structured interviews were conducted with 18 senior healthcare managers from three NHS Boards in Scotland in order to build an in-depth understanding of their attitudes and experiences regarding the use of social media patient feedback for improvement to health and care services. This chapter will explain and justify the research design and methods used for this study. Following this I will describe the data sources, participant recruitment, data collection techniques applied, and how the findings are analysed. The chapter ends with a consideration of ethics and data storage and confidentiality.

1.6.2 Patient Experience and Feedback

This chapter will critically review the relevant research literature regarding; the concept of patient experience, whether patients can judge their own care; methods

for capturing patient feedback, its use for informing improvement, and the impact patient feedback has on healthcare professionals. Having outlined the background and policy context for NHS Scotland, the remainder of the chapter will present and analyse data from the participant interviews to address the following questions: what do we mean by experience and specifically by patient experience; are patients able to judge the quality of their own care; how do we capture patient feedback; and how is patient feedback used for improvement.

1.6.3 Using Social Media as Patient Feedback

This chapter will critically review the relevant research literature regarding; how we define social media; what online methods are used for patient feedback; what are the benefits and challenges to using social media patient feedback for improvement; and how do we measure the impact and effectiveness of social media for patient engagement. The remainder of the chapter will report the interview analysis and identify the themes relating to the use of social media for patient feedback identified from the participant interviews: (i) barriers to the use of social media within healthcare organisations, and (ii) views from staff regarding the use of social media for capturing patient feedback.

1.6.4 Conclusions Chapter

This chapter will discuss the research findings in relation to the general body of knowledge, reflecting on the existing literature, the objectives of the study and the outcomes of the analysis. Following this I will discuss the implications of the research findings for healthcare policy and practice, and make suggestions for further research. Finally the remainder of this chapter will briefly outline the limitations of the study and make some personal reflections.

2. Methods

2.1 Introduction

In this chapter I will discuss, explain and justify the research design and methods used to explore the views of senior healthcare managers on the use of social media patient feedback for improvement to care and services. Following this I will discuss the data sources, participant recruitment, the data collection techniques applied, and how the findings were analysed. The chapter ends with a consideration of ethics and data storage and confidentiality.

2.2 Research Design

Research is concerned with the nature and generation of knowledge. Paradigms provide a means of generating this knowledge by giving the direction for research and allowing focused research. A research paradigm is defined as a "set of common beliefs and agreements shared between scientists about how problems should be understood and addressed" (Kuhn 1970). It is the overarching philosophical belief system or set of assumptions, which underpins the research itself (Schwandt 2015). The research paradigm relates to the researcher's ontological viewpoint (beliefs about the nature of reality) and their epistemological viewpoint (beliefs about the nature of knowledge) (Patton 2015). These philosophical assumptions guide the research methodology (how knowledge is acquired). A research paradigm inherently reflects the researcher's beliefs about the world that he or she lives in and wants to live in (Lather 1986).

There are two main opposing research paradigms: positivism and interpretivism (Hudson & Ozanne 1988) with a range of interpretations and positions in between. The positivist researcher believes in an objective reality, which is independent of the observer and that objective knowledge is produced deductively using rigorous

methodology and experimentation (Munhall 2001; Williams et al. 2018). Positivist researchers remain detached from the research participants, which is important in remaining emotionally neutral to make clear distinctions between reason and feeling (Carson et al. 2001). Quantitative research is generally based on the assumptions of positivism and involves collection of numerical data to explain a phenomenon. Conversely, the interpretivist researcher believes that reality is multiple and relative (Hudson & Ozanne 1988) and these multiple realities depend on other systems for meanings (Lincoln & Guba 1985). The knowledge gained through an interpretivist approach is socially constructed, rather than objectively determined (Carson et al. 2001). Rather than applying rigid structural frameworks, interpretivist researchers adopt a more personal flexible approach, which is more suited to understanding the motives, meanings, and experiences of the research participants (Neuman 2013).

I have adopted an interpretivist position in this research study. That is, I considered that there are multiple realities regarding the use of social media patient feedback by healthcare professionals for improvement, and we can only seek to understand real-world phenomena by studying this in detail within the context in which they occur. I believe this is particularly important and relevant to the Professional Doctorate, where the researcher is aiming to tackle real work based challenges and bring insight and value to their organisation and colleagues.

2.3 Type of Research

Having explored the paradigm that forms the basis of the research, it is important to identify the purpose and type of research being undertaken. A research design serves as the blueprint for the collection, measurement and analysis of data. It allows the researcher to locate oneself in relation to the research question and consider the relevant methodological considerations.

One way of categorising research designs is: descriptive; explanatory; and exploratory research (Saunders et al. 2009). A number of factors will influence the choice of research design, including research objectives, current knowledge,

research setting, timeframe, and cost considerations (Sekaran 2003). A description of the three research design categories follows.

2.3.1 Descriptive research

The cornerstone of descriptive research design is an accurate and systematic description of “something” or “someone” (Dulock 1993). Using surveys and fact-finding enquiries of different kinds, the major purpose of descriptive research is a description of the state of affairs, as it exists at present. Much of the research commissioned or undertaken by government, such as the population census or the collection of data on social indicators, can be classified as descriptive research (De Vaus 2001). In healthcare, descriptive studies are regularly used to monitor trends and plan for resources (Grimes & Schulz 2002). Good descriptive research provokes the ‘why’ of explanatory research.

2.3.2 Explanatory research

As the term implies, explanatory research is intended to explain, rather than simply describe the phenomena studied. Explanatory research is concerned with why phenomena occur and the influences or causal links that drive their occurrence (Ritchie & Lewis 2003). Typical objectives for explanatory research include, explaining the differences in two or more group responses or interpreting the cause and effect relationship between two variables (Malhotra & Grover 1998; McNabb 2009).

2.3.4 Exploratory research

Sometimes referred to as a grounded theory approach (Strauss and Corbin 1990) or interpretive research (Elliott & Timulak 2005), the main purpose of exploratory research is the discovery of ideas or insights. As such this research design is particularly useful in clarifying our understanding of a little known topic (Saunders et al. 2009) or the assessing phenomena in a new light (Robson & McCartan 2016). The research design tends to follow an inductive qualitative approach whereby the researcher uses observations and interviews to detect patterns and themes,

formulate some tentative hypotheses to be explored, and finally develop some general conclusions or theories.

With respect to this research study, the use of social media patient feedback for improvement to healthcare services, I have chosen to adopt an exploratory research design. This design is the most appropriate approach for providing insight into and an understanding of the topic, as well as providing an opportunity to define new terms and clarify existing concepts. The flexible nature of an exploratory research approach meant I could be adaptable to change and remain open to the potential for unknown elements to be encountered. By adopting this exploratory approach I will add to the limited knowledge base around social media patient feedback, improve our understanding of healthcare staff perceptions in this area, and inform healthcare organisations/policy makers in their efforts to improve the quality of care and services.

2.4 Research Methods

Where research design is the plan to answer the research question, research methods are the framework used to guide and implement that plan. The type of methodology adopted by the researcher depends upon the central research objective (Crabtree & Miller 1999; Denzin & Lincoln 2005). The crucial question for me in this study was not merely “what is the best research method?” rather “what is the best research method for answering this question most effectively and efficiently?” (Mays & Pope 1995). In social science research, one of the basic choices the researcher has to make is choosing between quantitative methods, qualitative methods or a mix of both. In this section I will describe the key characteristics of qualitative methods, the strengths and limitations of this approach, and how I have sought to address these limitations in the research design for this study.

2.4.1 Qualitative Methods – the key characteristics

The label 'qualitative research' is a generic term for a range of different research approaches. Merriam & Grenier (2019) assert, "qualitative researchers are interested in understanding the meaning people have constructed, that is, how people make sense of their world and the experiences they have in the world". Similarly, Denzin & Lincoln (2005) state, "qualitative researchers study things in their natural settings, attempting to make sense of, or to interpret, phenomena in terms of the meanings people bring to them." A more outcome focused and functional perspective is put forward by Guest et al. (2013) who state, "qualitative research involves any research that uses data that do not indicate ordinal values."

However, qualitative research is perhaps best understood by the characteristics of its methods rather than by a single definition. There are 4 key characteristics common to most methods of qualitative research (Sherman & Webb 1988).

1. Events can be understood adequately only if they are seen in context. Therefore, a qualitative researcher immerses him/herself in the setting.

2. The contexts of inquiry are not contrived; they are natural. Nothing is predefined or taken for granted.

3. Qualitative researchers want the research participants to speak for themselves, to provide their perspectives in words and other actions.

4. Qualitative researchers attend to the experience as a whole rather than as separate variables. The aim of qualitative research is to understand experience as unified.

By focusing on the qualities of the phenomena being investigated rather than their numeric measurement, qualitative methods allow the researcher to build a complex, holistic understanding of the phenomenon at hand.

A range of viewpoints, sometimes wholly opposed to one another, exists on the subject of qualitative research (Mays & Pope 1995; Rice & Ezzy 1999; Denzin &

Lincoln 2005; Patton 2015). In the next sections I will explore the strengths and the limitations of qualitative research and how these relate to the methodological choices I made for this study.

2.4.2 Strengths of a Qualitative Design

In qualitative research the objective is most often exploratory or descriptive, with an emphasis on understanding phenomena in their own right (Elliott & Timulak 2005). The descriptive nature of qualitative research allows the researcher to provide rich and detailed descriptions of human behaviour in the real-world contexts in which it occurs. Among qualitative researchers, this depth is often referred to as "thick description" (Geertz 1977). Furthermore, the rich descriptive nature of qualitative research enables readers to understand the meaning attached to the experience, the nature of the problem and the impact of the problem (Meyer 2001). In this study I chose to adopt a qualitative design in order to explore and get an in-depth understanding of senior healthcare managers' diverse and possibly contradictory perspectives regarding social media patient feedback. I felt that using qualitative methods would enable me to better understand the perceptions, emotions and actions of staff in much richer detail than could be obtained through a quantitative survey or questionnaire.

Qualitative research is most often associated with an inductive approach. With a focus on specific situations or people, qualitative methods give the researcher flexibility to build a complex, holistic picture from detailed views of participants in a natural setting (Creswell 1998). Another significant strength of qualitative methods is discovery through flexible, emergent research designs (Yilmaz 2013). This flexibility of approach allows the researcher to revise the direction and framework of research if new and fresh information and findings emerge. Quantitative methods, such as surveys and questionnaires, generally require a thorough understanding at the outset of the important questions to ask, the best way to ask them, and the range of possible responses. However qualitative methods are typically more adaptable, in that they allow greater spontaneity and adaptation of the interaction between the researcher and the research participants. For example, a research participant may

talk about an area early on in the interview of their own volition that the researcher was planning ask about later but they would then not need to ask the participant about it.

The key strengths of qualitative research are summarised below:

- Issues can be examined in detail and in depth.
- Interviews are not restricted to specific questions and can be guided/redirected by the researcher in real time.
- The research framework and direction can be quickly revised as new information emerges.
- Subtleties and complexities about the research subjects and/or topic are discovered that are often missed by more positivistic enquiries.

(Anderson 2010)

2.5 Why choose a qualitative methodology for this study?

The main reason I chose qualitative over quantitative methods in this study is that qualitative methods are more effective in building an in-depth understanding of behaviour or experiences and uncovering the meaning people ascribe to those experiences (Danforth & Glass 2001). A qualitative design was also integral to the study's philosophical underpinning of interpretivism. Qualitative research from an interpretivist point of view seeks to understand the meanings in human action. Furthermore from a practical point of view a qualitative approach was the most suitable research method to answer the research questions in this study. This is due to two reasons: (1) they are largely exploratory in nature, and (2) their purpose is to gain insight into a topic on which little literature exists. The character of this study requires a person-centred approach to understanding perceptions, emotions and actions of healthcare staff, which could not be acquired through a standardised

questionnaire with predetermined answer categories as used in quantitative research. The aim for this study was not to measure or quantify something, but to improve understanding of the use social media patient feedback by obtaining information from senior healthcare managers on their personal experiences, the meanings they put on it, and how they interpret what they experience. The exploratory nature of this study further supports the use of qualitative methods of inquiry. Given that qualitative methodology uses context, individual experience, and subjective interpretation, generalisability is not possible in this study, nor was it a goal (Noble & Smith 2015). I will explore the subject of generalisability in more detail later in this chapter.

For explorative studies, as used in this thesis, qualitative methods enable the researcher to describe and understand the experience, ideas, beliefs and values of the research participants. The main objective of this study is to explore the perceptions and views of senior healthcare managers in regard to the use of social media feedback for improvement. Instead of measuring the phenomenon of patient feedback by numbers, this thesis uses open questions to explore the staffs' perspectives, emotions and actions. By doing so I have sought to contribute to a better understanding of the phenomenon and to draw attention to processes and meaning patterns.

2.5.1 Limitations of a Qualitative Design

Despite the many strengths outlined above, it is important that researchers are aware of the limitations associated with qualitative research methods so that measures can be put in place to try and minimise the effects of these limitations (Barbour 2001). In the following section I will discuss the limitations of qualitative methods and describe how I have addressed these shortcomings in this study.

(1) Researcher Bias

All research is vulnerable to bias – and this includes qualitative research (Chenail 2011). Potential reasons for researcher bias in qualitative research include the knowledge, skills and previous experience of the researcher, and their value

preferences or affinity to certain kinds of people, theories and concepts (Poggenpoel & Myburgh 2003). As researchers, our 'external reality' is inseparable from what we already know based on our life experiences – our 'inner reality' (Krieger 1991). Therefore the reality we see is based on our understanding of the world, which in turn is based on our knowledge of the self. In qualitative research it is not possible for the researcher to separate themselves from the topic or people they are studying (Toma 2000). Indeed it is in this interaction between the researcher and the researched that the knowledge is created. Lincoln & Guba (1985) caution that any biases, motivations, interests or perspectives of the researcher are identified and made explicit in qualitative research.

(2) Generalisability

Generalisability is the extent to which it is possible to generalise from the research data to broader populations and settings (Terre Blanche et al. 2007). Generalisability is important when researchers want to make universal theoretical claims or to describe populations. There are a number of opposing and sometimes overlapping views put forward by researchers regarding generalisability in qualitative research. In this section I will briefly explore these arguments and try to draw out the insight regarding this controversial topic

Some authors, including qualitative researchers, believe that generalisation from qualitative research is inappropriate or unwarranted. In referring to qualitative research Lincoln & Guba (1985) state that "The only generalization is: there is no generalization". A similar position is taken by Wolcott (2005) who states, "how do you generalize from a qualitative study? [You] might answer candidly and succinctly, 'you don't'. That is a safe and accurate answer."

However there are many others who assert that generalisation from qualitative research is both possible and important (Collingridge & Gantt 2008). Naturalistic generalisation is a process where the reader gains insight by reflecting on the practical, functional applications of the research findings (Stake 1995). When applying naturalistic generalisation it is the readers of the research that apply the

transfer of knowledge themselves. As the readers recognise similarities in the research findings and discover descriptions that intuitively fall in line with their own experiences they consider whether their situations are similar enough to warrant generalisation (Melrose 2009). This form of generalisation builds on the reader's tacit knowledge (Lincoln & Guba 1985) and generates possibilities for transferring knowledge.

A number of researchers have argued that qualitative research represents a distinctive paradigm and therefore cannot be judged by conventional measures of generalisability (Hammersley 1990; Glaser & Strauss 2009). Indeed Thorne & Darbyshire (2005) assert that some qualitative research studies in healthcare express "overgeneralizations that spill out from the conclusions," which merely continues the criticism by some of qualitative research.

(3) Reliability

The terms reliability and validity are synonymous with assessing the quality of quantitative research (Cypress 2017). Joppe (2000) defines reliability as "the extent to which results are consistent over time and an accurate representation of the total population under study … and if the results of a study can be reproduced under a similar methodology, then the research instrument is considered to be reliable". Implicit in this definition is the idea that results from research can be replicated or repeated elsewhere. Stenbacka (2001) argues however that since the concept of reliability concerns measurement it is not relevant in qualitative research and "if a qualitative study is discussed with reliability as a criterion; the consequence is rather that the study is no good". Likewise Denzin & Lincoln (1998) assert that qualitative research is focused on meaning, interpretation and context, and as such "reliability in the traditional sense of replicability is pointless". As the ontological, epistemological and methodological assumptions of qualitative research are so clearly different from those of quantitative research, then it has to be judged on its own terms (Yilmaz 2013).

(4) Validity

Validity refers to (i) the integrity and application of the methods undertaken and (ii) the precision in which the findings accurately reflect the data (Long & Godfrey 2004). More simply, validity represents the truthfulness of research findings (Altheide & Johnson 1994). These definitions are somewhat at odds with the underlying assumptions and principles of qualitative research, which seeks depth over breadth and attempts to learn subtle nuances of experiences as opposed to aggregate evidence (Ambert et al. 1995). However, validity criteria and methodological procedures are crucial to protect against the researcher inventing concepts and theories that do not truly represent the phenomenon under concern (Hammersley 1992). Lincoln & Guba (1985) have proposed 4 criteria for qualitative researchers in pursuit of a trustworthy study:

a) Credibility - confidence in the 'truth' of the findings
b) Transferability - showing that the findings are applicable in other contexts
c) Dependability - showing that the findings are consistent and could be repeated
d) Confirmability - the extent to which the findings of a study are shaped by the respondents and not researcher bias, motivation, or interest

In the next section I will discuss the steps I have taken to promote and demonstrate the credibility, confirmability and transferability of my research findings.

2.6 Provisions made to promote and demonstrate credibility in this study

There are no mechanistic solutions to limit the likelihood that there will be errors in qualitative research. There are however various methods or provisions that can be made by researchers to promote confidence that they have accurately recorded interpreted and reported the phenomena under scrutiny. As in quantitative research, the basic strategy to ensure credibility and trustworthiness in qualitative

research is robust and reflexive research design, data collection, interpretation, and reporting. I will describe below the strategies I have used to enhance the trustworthiness of this study.

(1) Reflexivity

Reflexivity was an important element of the research process and I have included a section on my personal reflections of this study in the conclusions chapter. Patton (2015) describes reflexivity in qualitative research as a way of emphasising the importance of self-awareness, political/cultural consciousness and ownership of one's perspective. Throughout this study I have tried to remain open minded and alert to my own biases, beliefs and pre-existing knowledge. A reflexive journal is one method that helps researchers to address the distortions or preconceptions they may unwittingly introduce in their qualitative designs. I used an informal research journal for this study to record my thoughts, feelings, actions and reflections through the different stages of the research. This helped me to understand "what do I know" and "how do I know what I know" (Guillemin & Gillam 2004). These notes and thoughts in my journal made me more aware of prejudices and subjectivities, and the potential impact of these influences on the credibility of the research findings. I also used my research journal to record the emerging themes from the first few participant interviews. These themes were then pursued in subsequent interviews to sense check my own interpretations and build on emergent themes with subsequent interviews. I use my journal to record the 'eureka moments' and the 'doldrum moments' in my studies. Writing reflexively has helped me separate out my own personal experiences from those that arose from participant accounts of their experiences.

(2) Researcher Bias

As the researcher in this study it was important that I tried to recognise any personal biases and remain critically self-reflective about my own preconceptions regarding the processes by which data were collected, analysed, and reported. I found this a particular challenge as a Professional Doctorate student, where the aim is to create and interpret new knowledge associated with my own professional practice. In the

Professional Doctorate there is no clear boundary between outsider and insider for the researcher undertaking their own research in the professional setting (Dwyer & Buckle 2009). Acknowledging this influence and the potential effects on my behaviour has facilitated greater self-scrutiny throughout the research process. An awareness of my insider researcher status helped me to look past my own personal beliefs and mitigate the potential for my own biases in this research. Preconceptions brought about through an understanding and familiarity with the subject could have led me to over emphasise the benefits of social media in capturing patient experience. It is easy to be seduced by your own personal prior beliefs and expectations. However I was alert to this at the outset and put in place steps to minimise any bias, including interviewing a range of staff from senior clinical and managerial roles to ensure multiple views and experiences; ensuring that my interview questions were not steering particular responses; applying robust data analysis; and most importantly making sure to conclude only what the research results indicated.

(3) Peer scrutiny

Neutrality and impartiality are not easy stances to achieve. All researchers bring their own preconceptions and understandings to the problem being studied, irrespective of the methods used. In this study I sought out opportunities for questioning and challenge from peers, colleagues and from my academic supervisor. Whilst my closeness to the study had the potential to inhibit my ability to view it with real detachment, the fresh perspective brought by my peers and colleagues provided constructive challenge to any assumptions I might have. Their questions and observations really helped me to refine my methods, develop a greater explanation of the research design and strengthen my arguments.

(4) Sampling

Credibility was further enhanced in this research study through the use of purposeful sampling (Palinkas et al. 2015). I used this sampling method to ensure there was a good spread of healthcare organisations (rural and urban geography; ethnic

diversity; indices of social deprivation) and a broad range of research participants (nursing, medical, patient experience, quality improvement, communications) with different attitudes and experiences. Although this method of sampling does not secure a representative sample for generalisability, it does go some way to ensure that the healthcare organisations and participants involved in this study reflect the diverse nature of the workforce in terms of their professional background, knowledge and experience; thereby increasing the transferability of the findings.

(5) Thick Descriptions

This study uses ‘thick descriptions' (Lincoln & Guba 1985) and detailed quotes from participants in order to reveal internal coherence in the findings and establish credibility. This is analogous with internal validity in quantitative research (Riege 2003). By providing detailed descriptions of the range of views and perceptions of senior healthcare managers on the validity of social media feedback and the barriers to using this information to inform improvement I wanted to go beyond surface appearances to include the context, detail and emotion that would allow readers to make an informed judgment about whether they can transfer the findings to their own situation. Without this detailed insight, it is difficult for the reader to determine the extent to which the overall findings from the study “ring true”.

2.7 Audit Trail

I have clearly described and documented an auditable account of the research process from the start of this study through data analysis to the development and reporting of the findings. This will enable the reader to understand where and why decisions have been taken about theoretical, methodological and analytic choices and associate these with their own conclusions, which they will have drawn from the information provided.

A summary of the strategies used in this study to ensure the credibility of the findings is included in Table 1.

Table 1: Strategies Used to Ensure Credibility of Findings

Quantitative Research Terminology	Alternative Qualitative Research Terminology	Strategies Used in this Study to Ensure Credibility of Findings
Generalisability The degree to which the results of a study can justifiably be generalised, or applied, to a larger population or to other similar groups (Kerlinger & Lee 2000; Polit & Beck 2010)	Transferability The degree to which the results of qualitative research can be transferred to other contexts or settings with other respondents (Lincoln & Guba 1985)	• Thick verbatim descriptions of participant accounts were used to enable the reader to evaluate the study findings and assess whether my findings are transferrable to their own setting. This includes a rich account of descriptive data such as the context in which the research has been carried out, the setting, the sample, sample strategy, interview procedure and topics.
Reliability The extent to which results are consistent over time and an accurate representation of the total population under study (Joppe 2000)	Trustworthiness Credibility - confidence in the truth of the findings with regard to the subjects of research and the context where it was conducted (Sandelowski 1986) Dependability - ensure consistent data collection without unnecessary variations to	• Recognising and mitigating against my own researcher bias • Transparent and clear description of the research process through the development of methods and reporting of findings • Interviews with senior healthcare managers from different clinical disciplines and leadership positions to

	ensure repeatability of the research process (Lincoln & Guba 1985) Confirmability - ensuring that the research process and findings are not biased, hence it refers to both the researcher and the interpretations (Baxter & Eyles 1997)	bring different perspectives on the use of social media patient feedback • Emerging themes were discussed with my Acadenic Supervisor in an open process where assumptions could be challenged
<u>Validity</u> The integrity and application of the methods undertaken and the precision in which the findings accurately reflect the data (Heale & Twycross 2015)	<u>Reflexivity and reflection</u> Documenting reflexivity and reflectivity of the researcher is helpful in considering how the researcher affects the research participants, how participants affect the researcher and how the experiences, feelings and background of the researcher can affect his/her observations (Patton 2015)	• Robust record keeping to demonstrate and ensure that interpretations of the data are consistent and transparent • An 'audit trail' so that the pathway of decisions made during framework analysis can be checked by others • Digital recording of participant interviews to allow repeated revisiting of the data to check emerging themes • Reflective journal maintained to examine my own explicit/implicit assumptions and pre-conceptions, and document decisions

2.8 Data Sources

NHS Scotland currently employs approximately 140,000 staff working across 14 territorial NHS Health boards. Each NHS board is accountable to Scottish Ministers, supported by the Scottish Government Health and Social Care Directorates (NHS Scotland 2003). Health boards in Scotland vary considerably in size and function, ranging from the smaller distinctive boards of Orkney and Shetland to the large boards such as Lothian and Greater Glasgow and Clyde. NHS boards are responsible for the protection and the improvement of their population's health and for the delivery of frontline healthcare services.

In selecting the NHS boards for this research study I sought to include variation in relation to the populations served by these sites (rural and urban geography; size and scale; indices of social deprivation; complexity of case mix). Personal relationships and professional knowledge were also important for identifying appropriate senior clinicians and managers with whom to make initial contact to introduce the study. I approached and negotiated the participation of three NHS boards for my research study. The names of these three NHS boards have been anonymised in order to protect the identity of the research participants in this study.

2.8.1 Recruitment

In recruiting senior healthcare managers from the three healthcare organisations an approach involving a mix of purposive, and snowballing sampling was adopted. Purposive sampling involves choosing individuals based on particular features or characteristics, which are viewed as being central factors to the study's aims (Mason 2002; Patton 2015). Snowballing sampling involves identifying potential participants by asking those already involved in the study if they can identify individuals who they anticipate would be able to give an opinion on the topic (Lewis-Beck et al. 2004). The Directors of Nursing within NHS Boards in Scotland have the executive lead for setting strategy and utilising feedback from patients and the wider public to directly improve practice and patient experience. I initially approached the Director of Nursing in each healthcare organisation and asked them to

identify individuals from clinical services, senior management, patient experience and communications that might be willing to take part in the interviews.

There were 18 participants (6 from each healthcare organisation) recruited for this research study. The participants held the following positions in one of the three healthcare organisations:

Table 2: Research Participant Job Titles

Research Participant	Number
Medical Director	2
Nurse Director	2
Clinical Co-ordinator	1
Patient Feedback Manager	1
Head of Communications	3
Patient Information & Experience Manager	1
Quality Improvement Lead	1
Senior Nurse	2
Senior Charge Nurse	2
Director of Quality	1
Head of Primary Care	1
Head of Efficiency, Improvement and Innovation	1

In order to protect participants' identities and prevent deductive disclosure, the participants' names in this study have been replaced with ascending code numbers (P1 – P18) in the order of the interviews undertaken. The decision to anonymise participants was rewarded with frankness and a level of honesty that might not have been forthcoming had the data been attributed.

2.9 Participant information and consent

Potential research participants were sent an Invite Letter (Appendix 1) and a Participant Information Sheet (Appendix 2) and given the opportunity to discuss the project verbally with the researcher. The Participant Information Sheet explains the aims, methods, anticipated benefits and potential hazards of the study. The Participant Information Sheet

also confirmed that the transcript would be anonymised and that any extracts from the transcript included within this thesis or in future publications would protect individuals from being identifiable. If, after reading the information sheet, the participant agreed to be interviewed, their consent was obtained by asking them to sign two copies of the consent form (Appendix 3), one for themselves and one for the researcher's records. No study specific interventions were done before informed consent was obtained. It was made clear to participants that they were free to refuse any involvement within the study or alternatively withdraw their consent at any point during the study and for any reason.

2.10 Data Collection

Semi-structured key informant interviews (Bowling 2009) were selected as the method of data collection in this study for three reasons. Firstly, this approach allows the participants to respond freely, illustrate concepts and present individual perspectives that can be explored further. Secondly, a semi-structured interview guide increases the likelihood that the researcher can cover the topics of interest in an efficient manner. Thirdly, the guided approach provides the freedom and adaptability to investigate issues that may arise in the interview and are not addressed by the interview guide (Dicicco-Bloom & Crabtree 2006). A copy of the semi-structured interview guide used in this study is included as Appendix 4.

The themes for these semi-structured interviews were organised around the issues identified through my review of the literature relating to social media patient feedback that formed the basis of the research question. In order to pursue useful lines of inquiry and elicit greater detail from the interviewees I did not always follow the same order of questions or use the same wording but aimed to cover all themes during all interviews. The interview guide was just that, a guide, it was not set in stone. Each interview was different and participants raised points that were important to them. I wanted to give participants the opportunity to share information in their own words and in their own way. This made the qualitative interviewing both interesting and rather challenging to conduct. It is not easy to ask questions, listen to participants, pick up on cues about when to follow up or move on, and knowing when to simply let the participant speak without guidance or interruption.

2.11 Pilot Interviews

It is recommended that novice researchers test their interview guide to ensure the questions are appropriate and to provide the opportunity to enhance interview techniques (Kvale & Brinkmann 2014; Gerrish & Lathlean 2015). In this study, I used the first two interviews to pilot test the interview guide, assess whether the question sequence flowed, establish whether the data gathered answered the research question and to decide the length of time I required for each interview. The pilot process also allowed me to build confidence in my limited research interviewing skills.

The first two research interviews, one with a Nurse Director and one with a Medical Director, lasted around 60 minutes each. This provided me with a helpful guide as to the length of time each future interview might take. Following these two initial interviews, I made minor changes to the sequencing of the interview questions. Otherwise no changes were made to the content of the interview guide. From a practical perspective, these pilot interviews reinforced to me the need to put participants at ease to in order facilitate greater trust, hopefully resulting in richer and more detailed data.

All interviews were conducted face-to-face at the healthcare organisation. Conducting the interviews face to face allowed me to ensure the questions were understood by participants and provided the opportunity for follow up if required. Each interview was digitally recorded and lasted between 40 and 90 minutes. I made some reflective notes in my research diary immediately after each interview and then transcribed the interview into Microsoft Word.

2.12 Data Analysis

Qualitative analysis transforms the data into findings. It is a process of reflection and iteration that starts at the outset of data collection and aims to get behind the text to understand the real experience. There is no one agreed approach to analysis and decisions about the choice of methods will depend on the nature of the data, the researcher's

epistemological orientation and their personal views. Crabtree & Miller (1999) describe qualitative analysis as much as an 'art' as it is a science.

There are a range of techniques used by researchers for qualitative data analysis, including discourse analysis (Coulthard 1985), documentary analysis (Bowen 2009), oral and life histories (Leavy 2011), ethnography (Wolcott 1999), and participant observation (Jorgensen 2015). These methods all take the collected qualitative data and transform it into explanations, understanding and interpretation of the individuals and situations under investigation.

I assessed the relative strengths and weaknesses of the range of methods for analysing qualitative information and considered framework analysis to be the most appropriate method for analysing my interview transcripts (Smith & Firth 2011). Framework analysis is gaining increasing popularity in the field of healthcare research (Gale et al. 2013). This method of qualitative analysis originated in Social and Community Planning and was developed by qualitative researchers, Jane Ritchie and Liz Spencer (Ritchie & Spencer 2002). Whilst many qualitative data analysis methods are associated with specific disciplines and are underpinned by philosophical ideas that shape the process of analysis (Gale et al. 2013), framework analysis is not aligned with a particular philosophical or theoretical approach. I found it to be a flexible and adaptable methodology that allows both pre-determined and emergent themes arising from the data to guide the development of the analytic framework (Gale et al. 2013). This method of analysis was most suited to my study aims, as I wanted to explore specific questions and pre-defined issues, as well as remaining open to the unexpected. As a novice researcher I was particularly attracted by the methodical processes and spreadsheet approach used in framework analysis. Using this method of data analysis a framework matrix is developed to summarise and analyse qualitative data in a two-by-two spreadsheet table: rows (cases), columns (codes) and 'cells' of summarised data, provide a structure into which the researcher can systematically reduce the data, in order to analyse it by case and by code. The key features of framework analysis defined by Ritchie & Spencer (2002) are set out in Table 3.

Table 3: Key Features of Framework Analysis

Feature	Description
Grounded or generative	Driven by the original accounts of the people it is about
Dynamic	Open to addition and amendment throughout the process
Systematic	A methodical approach to analysis
Comprehensive	Full, partial or selective review of the material
Between and within case analysis	Enables comparison between and within cases
Accessible to others	Process and interpretation can be judged by others

Qualitative methods can be applied to answer a range of research questions. These can been broken down into 4 main categories (Ritchie & Spencer 2002)

- Contextual: Identifying the form and nature of what exists
- Diagnostic: examining the reasons for, or causes of, what exists
- Evaluative: appraising the effectiveness of what exists
- Strategic: identifying new theories, policies, plans or actions

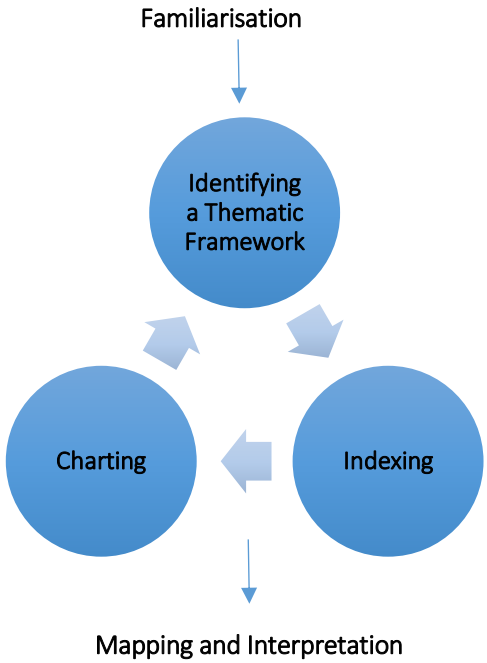
I found this typology of research questions very useful in thinking about my own data analysis. I was particularly interested in exploring what patient feedback means to NHS staff and its use in quality improvement (contextual), as well as finding out about the enablers or barriers to using feedback provided through social media (diagnostic). In terms of evaluative questions I wanted to know why it works well in some areas and less so in others, and what we can learn and share from this. With regard to the strategic questions, I was interested in staff views as to the future of social media for engaging and communicating with patients. The flexibility and adaptability of the framework analysis approach makes it a good choice for answering these questions.

Many researchers choose to use software to manage and analyse their qualitative data. NVivo is possibly one of the most well-known and widely used software tools utilised by researchers (Welsh 2002). For this study I chose not to use software and instead preferred to undertake the data analysis manually as I felt it would allow me to engage with and immerse myself more thoroughly in the data. Using a manual method I could physically move the data from one analysis sheet to another and carefully consider the 'fit'. On a practical level there were cost implications to using software analysis and I felt the time spent learning to use the software would be better used to familiarise myself with the interview transcripts.

2.13 The Process of Carrying Out Framework Analysis

There are five stages of framework analysis outlined by Ritchie & Spencer (2010): familiarisation; identifying a framework; indexing; charting; and mapping and interpretation. It is an iterative and recursive process used to find patterns in the data and make sense of them.

Figure 1: Framework Analysis



In the following sections, I have described how I used each of these stages in this study, as well as highlighting some of the challenges that arose and how I tried to resolve those challenges.

1. Familiarisation

Familiarisation is a characteristic of the majority of qualitative approaches; Ritchie & Spencer (2002) describe it as a "process of immersion". The purpose of this stage of framework analysis is to get a holistic sense of the data and a feel for any early emergent impressions. In practice, this involves listening to the interviews, reading interview transcripts and noting any initial issues in the data. I found it to be a to and fro process where the familiarisation and framework development interact with each other. I started the process of familiarisation by listening back to the research interviews, it is important to know WHAT the interviewees say but also HOW they say it. Indeed it is suggested "the closer you get to the text itself, the closer you are to its meaning" (Atkinson 2001).

Rather than use a professional transcription service, I chose to undertake the interview transcription task myself. The full interview was transcribed verbatim for each participant interview. Although this was time consuming, I felt it really brought me closer to the data and allowed me to critique and improve the interview process as I went along. I recognised early on that it was not my role as researcher to judge or approve the participant's responses; I had to be open to listen to everything they wanted to tell me. Importantly it also made me reflect on how my own position changed how I listened to the interviews. Alongside my reflective notes I was also listening to the participant interviews for potential early themes and also mindful of any individual differences inherent in the interview transcripts that may well have become lost when I began the coding. I found that this attentiveness to the individual differences at the familiarisation stage helped me to identify any within and between participant differences.

I then thoroughly read and re-read each transcript, recording anything that seemed of interest or significance, as well as any impressions, thoughts and ideas I had in light of my research question. From these initial notes, I went on to develop a set of preliminary codes for different aspects of the participants' views and experiences, with illustrative extracts

from the transcripts for each one. An example from my interview transcript notes and initial coding is included at Appendix 7.

2. Identifying a Framework

It is important that the research data is organised in a meaningful and manageable way to facilitate the later exploration during the mapping and interpretation stages of analysis. There is a risk that material could be missed during the analysis stage if the researcher is overly focused on trying to carefully fit data to a pre-determined outcome. Ritchie & Spencer (2002) recommend that the process of developing framework categories should be informed both by a priori concerns as well as emergent issues arising from familiarisation with the data. By including both a priori and emergent issues the framework is focused not just on the research questions but also includes those issues most pertinent to participants.

There is an element of trial and error involved to identify the categories that best fit the data and the research questions. Referring to my notes from the familiarisation stage I used the key issues, concepts and themes expressed by interview participants to form a broad set of preliminary codes as the basis for the thematic framework. I also included an 'other' code for those issues that did not fit neatly into the emerging framework codes. At this early stage in the analysis process the thematic framework was tentative and I was aware there would be opportunities to refine it later in the process. Keeping in mind this is a 5-stage process it was important to maintain the distinction between 'identifying a framework' and 'mapping and interpretation'. An example of the preliminary codes relating to barriers to the use of social media patient feedback is included below at Table 4.

Table 4: Example of Preliminary Coding

Preliminary Codes
• Cultural and Organisational • Inequality in access to internet and social media • Organisational, professional, personal reputation • Patient identification issues

- Policy and Legality
- Technical & Digital Literacy

3. Indexing

The third stage of framework analysis involves data reduction through comparing and contrasting data, and indexing transcripts using the systematic application of codes to the whole dataset. Each code was written directly onto the transcripts. Ritchie & Spencer (2002) highlight the risk that this could quickly become a rather mechanistic process and it is important for researchers to maintain "an intuitive and imaginative stance". It was increasingly evident to me during this stage that framework analysis is not a linear process and my thematic framework was constantly evolving as more data was added. Consistent with the findings of Richie and Spencer (2002), the thematic framework was refined as it was applied to the interview data, as new codes, particularly those at the secondary level, emerged and were added. The fluidity of the thematic framework therefore allowed new and important issues to be explored.

4. Organise the Indexed Data into Charts

Pope et al. (2000) describe the charting stage of framework analysis as a process of rearranging the data and thematic framework to create order. My experience through this project is that this is not a separate process that operates in isolation from the other stages. Rather it was a circular process with several rounds of examining the data as additional questions emerged and new connections were discovered to provide a growing understanding of the information (see Figure 1). Without this cyclical process between the framework, indexing, and charting phases then it is possible that I might have failed to identify some of the themes. The end product is a chart where each of the participant's interviews are summarised and organised by the framework categories (Ward et al. 2013).

5. Mapping and Interpretation

The mapping and interpreting stage of framework analysis brings all of the data together to identify the important issues and inter-connections. Ritchie & Spencer (2002) maintain that

"Although emergent categories, associations and patterns will have been noted and recorded during the index and charting phases, the serious and systematic process of detection now begins. It is here that the analyst returns to the key objectives and features...".

Guided by the research questions, I used the charts created in the previous stage to identify the patterns, associations, and explanations of the data. However analysis and interpretation is not a mechanistic process and I found this to be quite challenging – how would I know whether my interpretations were correct? This stage required a degree of instinct and intuition, and a lot of time until I had confidence that relevance and meaning was starting to emerge from the data. An example of the codes and sub themes for barriers and concerns identified through participant interviews is included below in Table 5.

Table 5: Development of 'Barriers and Concerns' Theme

Barriers and Concerns Theme		
Preliminary Codes	**Refined Codes**	**Sub Themes**
• Cultural and Organisational • Inequality in access to internet and social media • Organisational, professional, personal reputation • Patient identification issues • Policy and Legality • Technical & Digital Literacy	• Access to & use of technology • Anonymity, Confidentiality & Privacy • Vocal dissatisfied patients • Distant impersonal communications	• Anonymous nature of online patient feedback • Reputational Risk • Age and IT Skills of Users • Loss of Face-to-Face Communication

Limitations of Framework Analysis

Like many qualitative approaches, framework analysis is time and labour intensive. It took me on average 4-5 hours to transcribe a 60-minute interview and much longer for the analysis of the transcripts (i.e. coding, line-by-line reading and highlighting areas of interest).

There is a risk that framework analysis becomes a repetitive mechanistic process where researchers blindly follow the 5-stage process rather than taking a considered reflective approach (Parkinson et al. 2016). I tried to remain focused on my research study questions throughout the analysis and pay attention to the subjective ambiguous data that did not easily fit within the framework categories.

2.14 Ethics

This research project fully adhered to the principles outlined in the University Of Bath Code Of Good Practice in Research and was conducted in compliance with the Data Protection Act 1998, NHS Caldicott Principles, and the Scottish Executive Health Department Research Governance Framework For Health and Community Care 2006.

Research ethics approval was sought from and approved by the Research Ethics Approval Committee for Health (REACH) at University of Bath Department of Health (Reference ID: EP 15/16 254). A copy of the email confirming approval from REACH is included at Appendix 5. Approval was also received from the Integrated Research Application Service (IRAS) (Project ID: 194597). IRAS is the single system for applying for the permissions and approvals for health and social care / community care research in the UK. Copies of the approval letters from each of the 3 healthcare organisations involved in this study are included at Appendix 6.

Any research that includes people requires an awareness of the ethical issues that may be derived from such interactions. Qualitative researchers face particular ethical challenges in all stages of a study, from designing to reporting. These include anonymity, confidentiality,

informed consent, and the researcher's potential impact on the participants. I shall now address each of these potential ethical concerns in relation to this study.

(i) Anonymity & Confidentiality

To ensure the confidentiality of research participants in this study all information from the interviews was anonymised. This allowed me to maximise protection of participants' identities and at the same time maintain the value and integrity of the data. Furthermore, participants were assured that no personal data would be disclosed in the writing-up of the thesis and any future research publications.

Research participants were informed that all information provided was to be securely stored against access by persons other than the researcher for a period of five years. At the end of that five-year period all data provided by participants will be destroyed, paper records will be shredded and electronic records deleted.

(ii) Data Management & Protection

Thorough data management is crucial for the protection of people who participate in research. These data include confidential and often sensitive narratives, requiring additional data management procedures to protect research participants whilst allowing for effective data dissemination. A summary of data protection issues in this study and the steps taken to mitigate these concerns is included in Table 6.

Table 6: Data Protection Issues and Solutions

Data Protection Issue	**Solution**
Generation of personally identifiable data	All research interviews were anonymised and each participant was assigned a number for notation in the final data reporting
Security of hand written researchers notes and written participant products	Immediately following each interview, all notes were digitally scanned and hard copies destroyed
Audio recording security prior to storage	All interviews were digitally recorded to avoid the use of tapes which may be lost in transit

Security of digital audio files and data files	Recordings and transcription of recordings are stored on the Healthcare Improvement Scotland servers, which can only be accessed by users with assigned usernames and passwords
Data disposal	Transcriptions of recordings will be archived for 5 years from the end date of the study and then digitally destroyed

(iii) Informed Consent

Informed consent is an important part of ethics in research studies (Sanjari et al. 2014). For qualitative researchers it is essential to specify in advance which data will be collected and how they are to be used (Hoeyer et al. 2005). The principle of informed consent underlines the researcher's responsibility to inform all participants of different aspects of the research in clear and understandable language. This includes the purpose and scope of the study, the identity of the researcher, the types of questions likely to be asked, methods of anonymisation, and how the results will be published and used.

As the researcher in this study it was my responsibility to ensure that participants understood their rights, especially the right not to participate or to withdraw from the research at any time (Corbin and Morse, 2003), without giving a reason. Each participant was sent an Information Sheet that explained the aims, methods, anticipated benefits and potential hazards of the study. If, after reading the information sheet, the participant agreed to be interviewed, their consent was obtained by asking them to sign two copies of the consent form (Appendix 3), one for themselves and one for the researcher's records. No study specific interventions were done before informed consent was obtained.

(iv) Researcher / Participant Relationship

The participants' perceptions of the researcher, including their professional role, can influence the interaction, and hence the information that is revealed (Richards & Emslie 2000). One of my main concerns at the outset of my studies was the potential for blurring of the boundaries between my role as a researcher and my role as Senior Inspector with Healthcare Improvement Scotland (HIS). HIS provides assurance to the public about the quality and safety of healthcare through the scrutiny of NHS hospitals and services in Scotland. I am a senior member of the management team at HIS leading on quality

assurance and inspection of healthcare services, which involves regular interaction with the staff in the three healthcare organisations involved in this study. I was worried that my position at HIS could create an asymmetrical power imbalance and possibly influence the discussions and answers from research participants. Would they be open and honest? Would they tell me everything? To address these concerns I started by making it absolutely clear from the outset that this research project was completely separate from my role in Healthcare Improvement Scotland. It was important to distinguish between a request from me as a researcher and a request from me in my professional role. To address any potential researcher bias or role conflict in this study I critically examined my own role during the formulation of the questions, participant interviews, including sample recruitment and choice of healthcare organisation, and in data analysis and reporting. This self-reflective approach and an attitude of openness ensured there was no blurring of roles. I did not experience any resistance or lack of responsiveness from participants during interviews, nor did I feel that participants were holding back or felt unable to express their views openly and honestly. A detailed account of the steps taken to promote and demonstrate credibility of the research findings in this study is included in section 2.6.

2.15 Confidentiality, Data Storage and Security

Recordings and transcription of recordings are stored on the Healthcare Improvement Scotland servers, which can only be accessed by users with assigned usernames and passwords, and held in a project folder that can only be accessed with a further password. Transcriptions of recordings will be kept for 5 years on the secure servers at Healthcare Improvement Scotland.

2.16 Summary

This chapter has described the qualitative research design of the study and explained why such an approach was appropriate. The steps taken to collect the data from research participants using semi-structured interviews have been described. The data sources, process of framework analysis and strategies used to demonstrate credibility and

trustworthiness in the findings have been detailed. The ethical considerations and confidentiality have also been discussed. The next two chapters will describe the findings of the study.

3. Patient Experience and Feedback

3.1 Introduction

A series of interviews was carried out with senior healthcare managers from three NHS Health Boards in Scotland to explore the following research question:

What are senior healthcare managers' perspectives of using social media patient feedback to improve care?

In this chapter I will specifically focus on senior healthcare managers' perceptions on the validity of patient feedback as a method for taking account of patient experience and whether patient feedback can be used to inform improvements to care. Before reporting the results from participant interviews I will critically review the relevant research literature regarding; the concept of patient experience; whether patients can judge their own care; methods for capturing patient feedback; its use for informing improvement; and the impact patient feedback has on healthcare professionals.

3.2 Background and Policy Context for NHS Scotland

The Patient Rights (Scotland) Act 2011 (Scottish Government 2011) raises the focus of patient rights and responsibilities for healthcare organisations in Scotland. The Act makes provisions, which came in to effect on 1 April 2012, for the encouragement of feedback, comments, concerns and complaints about NHS services. The aim is to support the development of a culture that values and listens to the views of patients, carers and service users to help inform and improve the development and delivery of person-centred quality healthcare. Secondary legislation has also been published in relation to the handling of feedback, comments, concerns and complaints, namely the Patient Rights (Complaints Procedure and Consequential Provisions) (Scotland) Regulations 2012 ("the Complaints Regulations") and the Patient Rights (Feedback, Comments, Concerns and Complaints) (Scotland) Directions 2012 ("the Complaints Directions").

The Patient Rights (Scotland) Act 2011 gives all patients:

"*The right that the health care they receive should consider their needs, consider what would be of optimum benefit to them, encourage them to take part in decisions about their health and wellbeing, and provide information and support for them to do so*"

Particularly relevant to this study, the Act gives all patients:

"*The right to give feedback (both positive and negative) or comments, or raise concerns or complaints about the health care they have received. The Act also requires that Health Boards encourage, monitor and learn from the feedback and complaints they receive*"

In the light of this, Scottish Government has also issued revised good practice guidance to NHS Boards for the handling and learning from feedback, comments, concerns or complaints (Scottish Government 2012). The guidance, which has been developed as an interactive electronic resource, supersedes the 2005 guidance and reflects the provisions within the Patient Rights (Scotland) Act 2011 and the supporting Secondary Legislation.

Specifically the guidance states that NHS Boards in Scotland are required to develop local processes and procedures to ensure that they:

- encourage, welcome and view feedback, comments, concerns and complaints as opportunities for ensuring the NHS provides person-centred care
- promote learning and improvement from all forms of feedback received are credible, independent, transparent and easy to use for members of the public and staff
- empower staff to listen to and act upon feedback, comments, concerns and complaints

There are similar policy provisions in England, where the NHS Constitution sets out the rights to which patients, public and staff are entitled (Department of Health 2015). Principle 4 of the NHS Constitution (The patient will be at the heart of everything the NHS does) states "Patients, with their families and carers, where appropriate, will be involved in and consulted on all decisions about their care and treatment. The NHS will actively encourage feedback from the public, patients and staff, welcome it and use it to improve its services."

The Constitution also includes expectations that reflect how staff should play their part in ensuring the success of the NHS and delivering high-quality care. It states that staff should "welcome and listen to feedback and address concerns promptly and in a spirit of co-operation".

The policy and guidance from both Scotland and England raises questions about patients giving feedback on their experiences of the healthcare system and also having experiences of their feedback being sought out, valued and responded to. So as a first step it is then important to consider how best to conceptualise this.

3.3 What is experience?

The root of patient feedback is their experience. Organisations are asking patients to feedback on the basis of their experiences of healthcare and thus it is important to briefly consider the nature of experience. A term loaded with meaning and significance, experience can be an elusive concept to define. A review of the research would suggest alignment around three central themes that are critical to experience.

3.1.1 Subjective Experience

Experience is personal; a subjective phenomenon that occurs within the mind of the individual (Laing 1983). Our experiences are filtered through our own personal net of perceptions and biases (Bate & Robert 2006; Pritchard & Woollard 2010). These perceptions and biases, intended or unintended, shape our thinking and the way we experience the world (Reynolds & Subasic 2016). As a result, individuals exposed to ostensibly similar events or circumstances, will experience things quite differently.

3.1.2 Emotional Experience

All experiences have a strong emotional thread (McCarthy & Wright 2004) and it is these emotions that differentiate one experience from another. Our views, ideas, thoughts and emotions drive the movement of events toward an outcome that is desired or disliked

(Barrett et al. 2007). Thus, emotions can be seen as an integral component of our experiences that determine their valence (positive–neutral–negative) and intensity (high–low) (Ariely & Carmon 2003).

3.1.3 Time Related Experience

Experiences unfold over time through a stream of changing subjective circumstances that vary in intensity from moment to moment (Ariely & Carmon 2000). When people summarise their experiences they generally extract only a few important features, which are then combined into an overall summary evaluation. Such experiences are largely based on how the individual felt at its most intense point and at the end of the experience (Ariely & Carmon 2000).

In summary, human experience is constructed of meaning and not things - we learn in and through our experience. It can be understood as an individual's own subjective interpretation of events, made up of a complex fabric of emotions, expectations, thoughts, and actions that unfold over time and vary in intensity. In the next section I will consider how we conceptualise experience with regard to the patient and their use of healthcare services.

3.4 What do we mean by patient experience?

As discussed earlier in this chapter, it is increasingly the case that feedback from patients on their experience of healthcare services is seen as a driver for change. Patient experience is now considered one of the three pillars of quality in healthcare, along with clinical effectiveness and patient safety (Doyle et al. 2013). In his review of the quality of care in NHS England the Parliamentary Under Secretary of State Lord Darzi said, "If quality is to be at the heart of everything we do, it must be understood from the perspective of patients" (Darzi 2008).

There is however an absence of a commonly used definition around patient experience in healthcare. Patients, clinicians, politicians, managers and academics seem often to have something rather different in mind when they refer to patient experience (Shale 2013). Some patient experience definitions focus on the link to patient expectations (Bowling et al. 2013; Tahir et al. 2012; Mekonnen & Enquselassie 2016). Each patient attending a healthcare organisation will have their own personal expectations or anticipations about what to expect from their care. This could include expectations about healthcare structures (e.g. buildings, equipment, staff), processes (e.g. waiting lists, the way that staff and patients interact) and health outcomes (e.g. the effects of the health service on patients' health) (Bowling et al. 2013). The patient's experience is strongly tied to their expectations and whether these are positively realised. When their expectations are unmet patients are more likely to feel they have had a poor experience.

Other definitions of patient experience have focused more on patient centred care principles. Weiss & Tyink (2009) assert that the ideal patient experience is created through a patient-centric culture that is built on respect for the needs, wants, preferences and values of patients. This expands on the traditional bio-medical model to a broader bio-psycho-social orientation (Engel 1977), emphasising the need for healthcare organisations to know the patient as an individual, tailor care and services for each patient, and ensure patients can actively participate in their care (Staniszewska & Bullock 2012).

Shale (2013) differentiates three common approaches to thinking about patient experience. All three notions of patient experience are important and each is related to the others. First, illness is viewed from the perspective of philosophical naturalism. A naturalistic account presents illness as primarily a matter of biological dysfunction alongside objective indicators of clinical intervention. This objective notion of patient experience gives priority to the physical facts and presents illness purely as a biological dysfunction. I would argue that this entirely biomedical approach to describing experience is too narrow and does not adequately encompass the important elements of holistic patient care, such as health, well-being, quality of life, respect and dignity, independence and autonomy (LaVela & Gallan 2014).

Secondly, Shale states that healthcare organisations require some way of measuring 'customer experience' in order to identify whether they are meeting patient needs. Whilst Shale's first facet of experience focused on the clinical and physical health aspects of the patient experience, this second facet considers the patients' experience of healthcare system itself. This approach is particularly important in a quasi-market driven system, where patients are able to use this information to make an informed rational choice about their healthcare provider. This notion of patient experience is increasingly important to healthcare organisations in the UK where regulators use patient experience for activities such as registration, monitoring ongoing compliance and reviews (Healthcare Improvement Scotland 2019; Care Quality Commission 2019).

And thirdly, Shale says that patients need healthcare organisations to understand what it means to live with illness and experience treatment from the 'lived experience' perspective of the patient. This contrasts with the focus on understanding and measuring patient experience from the perspective of the healthcare organisation. Rather this first-person notion of patient experience requires us to consider illness and care from the perspective of the patient and understand what it means to be experiencing ill health and experiencing care.

Building on these definitions, our understanding of patient experience goes beyond considering illness simply as biological dysfunction but rather brings together the second two facets noted by Shale (2013) i.e. that patient experience comprises the holistic experience of being a patient, including their psychosocial needs and living with illness.

In sum, whilst there is no one consistent definition in the research, there is alignment around central themes seen as critical to patient experience. The most consistent concepts include: acknowledging the individual expectations and needs of the patient, understanding both the emotional and physical elements of experience, and recognising the importance of partnership/patient involvement.

Consideration and understanding of patients' experiences are increasingly recognised as essential in achieving high quality healthcare provision. Healthcare organisations across the world are actively seeking views from patients and carers about experience, safety and

quality. However there is disagreement amongst healthcare professionals as to whether patients are competent to judge the technical or clinical aspects of their care and thus whether it is legitimate to attend to patient experiences in this area. I will explore this further in the next section.

3.5 Can patients judge the quality of their own care?

Zinckernagel et al. (2017) describe a good patient experience as multidimensional. It involves technical or clinical aspects of care (such as the clinical competence of the staff, administering medication and helping patients to manage and control pain),'transactional' aspects of care (in which the individual is cared 'for', e.g., meeting the preferences of the patient as far as timings and locations of appointments are concerned) and 'relational' aspects of care (where the individual is cared 'about', e.g., care is approached as part of an ongoing relationship with the patient) (Murrells et al. 2013).

The relative importance of the technical aspects of clinical care versus the more relational dimensions like interpersonal exchanges and communication continues to foster debate amongst clinicians, managers and researchers alike (Bowers & Kiefe 2002; Westaway et al. 2003). Bopp (1990) argues that patients do not have sufficient knowledge to judge the technical competence of the hospital and the diagnostic skills of its staff. This stance is supported in research by Ben-Sira (1976), who found that patients' views about the technical skill and competence of clinicians was largely determined by perceptions of their personal qualities - primarily the extent to which the doctor was friendly and reassuring. Furthermore a qualitative study of patients in a review of general practice by Chapple et al. (2002) found that "relatively few patients had enough knowledge about their own particular illnesses or about possible alternative treatments to make informed judgements." Sitzia & Wood (1998) postulate that patients already assume a basic level of competence in the medical procedures undertaken upon them. As a result, the authors suggest that considerations such as the manner of clinicians and the comfort of the surroundings assume a dominant importance. Adopting a similar position, Wensing et al. (1998) argue that patients will assume a level of technical competence at both professional and organisational levels. To a certain extent this assessment is endorsed by Ware & Snyder (1975) who believe

that patients are unable to distinguish between the 'caring' (interrelational) performance and the 'curing' (technical) performance of clinical care providers. They report that when asked to assess the technical quality of an organisation or clinician, patients often substitute value judgments derived from the functional quality (e.g. waiting time, how the GP receptionist behaved etc.) to infer an answer about the technical aspects.

In contrast to those who argue that patients are unable to judge the technical aspects of their care, there are many who assert that patients have a legitimate and important role as evaluators of clinical performance. Indeed Coulter (2006) believes that it is a 'generalisation too far' to say that patients are unable to assess the quality of care they receive. Marcinowicz et al (2009) argue that patient feedback on the technical quality of care is a powerful way to build a more patient-centred healthcare service. This is supported in research by Elwyn et al. (2007) where patients reported that their views and preferences on quality of care must be considered at least equally important as those of healthcare professionals. The authors highlight the increasing importance of the patient perspective in quality control and quality improvement. This view is supported by Boiko et al. (2015), who write that "patients have the potential to be a very useful source of information on the quality and safety of care". Patients are often the only common link between the multitude of treatments, appointments and hospital stays that make up the healthcare experience. As such, they are uniquely placed and motivated to contribute to improving the quality of their own care (Ward & Armitage 2012). Other researchers have shown positive associations between overall ratings of patient experience and ratings of the technical quality of care. In a study involving 2429 US Hospitals, Jha et al. (2008) found a positive patient experience was associated with the quality of clinical care for myocardial infarction, congestive heart failure, pneumonia and complications from surgery. In another study, Isaac et al. (2010) reviewed the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) data from 927 hospitals in the US. The authors found patient experiences of care were related to measures of technical quality of care, thus supporting their validity as summary measures of hospital quality. Taken together, these studies support the notion that patients' views are a helpful source of intelligence on the quality of care and services. Work by Brearley et al. (2011) further emphasises the importance of relational aspects of care alongside the technical elements in terms of what is important to patients. The authors

refer to ‘being treated as a person’ and ‘being listened to’ as relational aspects of care that patients find most important.

Overall a review of the published research would suggest that health professionals and patients do differ in how they judge the quality of care. Where clinicians will judge quality based on clinical outcomes and effectiveness of treatment, the patients’ views are largely determined by their perceptions of the environmental and interpersonal aspects of care. Where patients put value on an experience that includes open communication and ease of service, clinicians will often focus on quantifiable measures like mortality, physical symptoms, length of stay and adherence to treatment. There is now a building evidence base to demonstrate that patient experience is linked to these clinical measures of quality. As healthcare organisations increase their focus on collecting and using patient feedback, more work will be needed to assess whether patients’ evaluations of the clinical aspects of care are any less reliable than those of healthcare professionals or whether patients are more influenced by other aspects of the experience than clinicians. Further research to improve our understanding of how patients prioritise the importance of clinical versus interpersonal elements of healthcare quality could help healthcare providers to better manage relationships with their patients.

3.6 What do we mean by patient feedback and how do we capture it?

Despite the complexity surrounding which definition of patient experience to embrace or which aspects to measure, healthcare organisations are increasingly focused on seeking feedback from patients to assess elements of the quality of care (Draper et al. 2001). Simply put, patient feedback is a patient’s account of events and/or views and opinions in relation to the care they have experienced (Picker Institute 2009).

Patient feedback has the potential to be a very powerful tool for healthcare organisations; it can inform and empower staff, as well as identify those weaker areas of the service that require attention (Tasa et al. 1996). The most effective healthcare organisations use feedback as a strategic tool (Yellen et al. 2002) - an opportunity to learn something about

their services they do not know already - and as an asset rather than a nuisance. As part of a systematic approach to quality, patient feedback can also help healthcare organisations communicate and interact with the population they serve, helping to improve the service provided (Draper et al. 2001). This organisational commitment to listening to patients and learning from their experiences is key to a coherent approach to quality improvement (Ham et al. 2016), and there is evidence to show that the systematic collection of data on patients' experiences can highlight and address aspects of the care experience that need improvement (Doyle et al 2013, LaVela & Gallan 2014, Wensing and Grol 2003). Overall, these studies provide good evidence for the usefulness of patient experience in highlighting strengths and weaknesses in the effectiveness and safety of care.

Patient feedback can be factual or descriptive in nature, as well as evaluative, which captures the patient's assessment of what happened (Wensing & Elwyn 2003). There are a range of mechanisms used by providers to collect feedback; whilst some feedback is volunteered by patients, other feedback is directly solicited by healthcare providers (Urden 2002; Drain et al. 2004). Patients will make their choice on how they wish to provide feedback based on a number of criteria such as ease of use, the perception that they would be listened to, and the likelihood that something would be done (Albert 2003).

Whether it is through surveys, questionnaires, telephone or focus groups, each method of providing feedback needs to be examined in terms of its validity, effectiveness and implementation. A systematic review and utility critique of questionnaires to measure the patient experience of healthcare quality was undertaken by Beattie et al. (2015). In a review of 11 international patient experience questionnaires the authors found that the quality of methods and results was variable but generally of a high standard. They concluded that there is no 'one- size-fits-all' approach to selecting an instrument to measure the patient experience of quality of care and that healthcare organisations must select patient experience instruments that are fit for purpose. A review of the literature to date shows that little attention has been given by researchers to understanding how health professionals assess the validity and effectiveness of the social media as a method of gathering feedback on the patient experience. My research will address this research gap

with respect to the validity and effectiveness of feedback gathered through social media as a means to inform improvement to health and care services.

In the next section I will move on to examine how, having gathered feedback from patients through a range of methods, healthcare organisations use this information to inform improvement, identifying some of the enablers and barriers to making this happen.

3.7 The Impact of Negative and Positive Feedback on Healthcare Professionals

Patient feedback involves the views and opinions of patients and carers regarding the care they have received (Doyle et al. 2013). Both negative and positive patient feedback can have an impact on the performance of healthcare professionals (Sargeant et al. 2008). Complaints or critical feedback can be demotivating or demoralising for healthcare professionals and evoke strong emotional reactions such as psychological distress, loss of self-esteem, anger, frustration, and fear of continued practice (Kluger & DeNisi 1996; Adams et al. 2018; Schrøder et al. 2019). These feelings are often long-lasting and damaging to the clinician's wider relationship with their patients.

As negative patient feedback often involves personal information about the character or performance of a healthcare professional, clinicians can find it difficult to treat this objectively (Ashford et al. 2003) and it is often rationalised by clinicians as signs of ingratitude or disregard for the individual efforts or services involved in providing care (Annandale 1989). Negative emotional reactions from healthcare professionals can interfere with their acceptance and use of patient feedback for improvement (Kluger & DeNisi 1996; Sargeant et al. 2006).

The professional culture in medicine places a value on, and indeed expects, adherence to high ethical and moral standards (Montagne et al. 2014). Research by DeNisi & Kluger (2000) suggests that this medical professional culture contributes to clinicians' apprehensions regarding negative feedback and their inclination is to construe this feedback

at the self-level. Helping medical staff to interpret the negative feedback at the ‘‘task’’ level and not as a general criticism of ‘‘self’’, could help to decrease emotional reactions and increase acceptance.

One of the most common reasons cited by patients for providing positive feedback online is to praise the service received by healthcare professionals (van Velthoven et al. 2018). Praise is a strong reinforcer of positive behaviours and has an encouraging impact on staff morale, confidence, growth and achievement (Lussier 2018). In a review of 245 adult mental health patient stories published on the Care Opinion website Baines et al. (2018) acknowledged the impact that positive feedback had on improving staff morale and the learning benefits associated with sharing this positive feedback (Baines et al. 2018). Similar findings were evident in a study of paediatric residents where participants valued positive patient feedback on their communication and interpersonal skills, particularly if it aligned with their self-perceptions. Positive feedback was frequently described by clinicians as “validating” and “reinforcing of strengths” (Bogetz et al. 2017).

However, positive feedback does not necessarily lead to actionable change in the behaviour and practice of healthcare professionals (Miller & Archer 2010; Kumah et al. 2018). Research by Edwards et al. (2011) examined the perspective of GPs in the UK regarding patient feedback. The researchers noted that whilst positive feedback was viewed as an affirmation of practice, participants felt this could lead to inaction, or complacency. The more sceptical study participants regarded ‘above average feedback’ as patients being unrealistically positive.

In the following results section of this chapter I will explore the following research question and sub-questions that were addressed in a series of interviews with senior healthcare managers from three healthcare organisations (see Methods Chapter for full details of the methods).

Research Question

What are senior healthcare managers’ perspectives of using social media patient feedback to improve care?

Sub-Questions:

(i) What do health professionals think of patient feedback as a way of capturing the patient experience?

(ii) Can patient feedback be used to inform improvements to healthcare delivery?

3.8 Results

Three main themes relating to patient feedback were identified from the interviews with staff: 'understanding and recognition of value', 'impact on staff and the organisation' and 'learning from and acting on feedback'. These were all considered to be frequent themes within the dataset and highly salient for the majority of the participants. The theme titles do not represent exact participant quotes; they have been assigned by the author so as to best describe the themes that were identified (Boyatzis 1998). The results from the three themes are reported below. Illustrative quotes are anonymised to protect participant and organisation identities and are extracted verbatim from original transcripts.

It should be noted that themes are presented as separate categories for the purposes of reporting, but that themes were found to inter-relate. The methods of data collection and analyses are described in detail in the Methods Chapter.

3.8.1 Theme 1 – Understanding and Recognising the Value of Patient Feedback

When asked in interview whether they felt that patients could judge the quality of their care, many staff referred to the subjective and mood oriented nature of patient feedback that is very much based on individual experience and expectations

"Everybody is different and people react differently to different situations. When people are unwell I think their expectations may be higher or beyond what can actually be achieved" (P3)

"It is very subjective if you're a patient and I don't know if you could actually make it more objective, I think that is quite a challenge" (P3)

"The person centred journey is very personal and will be different for everyone" (P1)

One participant went further, commenting "*when we get feedback from patients you've got to understand it is not pure and accurate*" (P8)

Feedback from patients is always going to subjective and influenced by past experiences, events, inner fears, and expectations. These comments show that staff may use the notion of patient subjectivity to dismiss or at least question the legitimacy of patient feedback.

Regarding patient feedback and whether this is subjective and effected by mood or disposition, one Senior Nurse responded

"If we have someone who has come through the system and they've had a long wait in A&E, they're sore and it has taken a long time to get their pain killers, the doctor hasn't spoken to them but has spoken to the other doctors around the bedside and the nurse has had to come back and explain, they have been moved around 3 or 4 wards. Absolutely, they are much more vocal about these things as opposed to somebody who comes in, has a short stay in A&E, has their analgesia straight away and goes to the correct ward" (P11)

In this example the interviewee seems to be suggesting that the patient would have a legitimate reason for providing feedback on what would be a particularly poor patient experience. However there is a sense here that patient feedback in a situation like this is expected but so obvious and self-evident that it doesn't merit further investigation. However, without any further exploration, in this example certainly, it is possible that staff could miss important signals around problems with triage systems, pain control or ward transfers.

Some participants further questioned the validity of patient feedback, arguing that it is shaped by a range of factors outside the influence of the healthcare organisation, such as "*prior experiences of family members or friends*", "*level of family support*" and "*tiredness or depression*".

In sum, in these examples, the notion that patient comments are subjective is deployed to invalidate or at least to undermine the legitimacy of patient experience.

A number of participants in this study also suggested that whilst patients may be able to evaluate the interpersonal and relational aspects of their care experience, they are not educated or informed enough to judge the clinical aspects of their care, for example:

"*the interpersonal relationships, most people would be in a position to feedback on that. But I think getting in to the technical things and tests, unless someone really knows enough about it and why it's been done and what it's going to involve then they are not in the best position to feed back*" (P2)

"If the general public were more informed of the technical side rather than the interpersonal relationships they would be able then to give valid feedback" (P3)

These comments show that some senior healthcare managers believe that patients lack the necessary knowledge to make an evaluation of the clinician's technical skills and instead should feedback only on the interpersonal and relational aspects. It is possible however that patients in their evaluation of quality may prioritise the softer aspects, such as concern, caring, and sensitivity, whilst taking for granted that the healthcare professionals have the necessary technical skills.

In contrast to the earlier comments from participants regarding subjectivity, other senior healthcare managers in this study acknowledged that when it comes to patient feedback, perception is reality. The implication is that because each of us perceives the world through our own eyes, reality itself changes from person to person. In the quotes below, the interviewees recognise and accept that all feedback is subjective, but in contrast to the above, they do not believe that this makes it any less legitimate.

"Each individual has his or her own perception, patients are indeed able. I think that all feedback is valid because it's about their personal experience" (P16)

"It is their experience and it's their perspective of their experience so that is what is most important" (P6)

"Actually it is not about necessarily fact checking, it is about people's perceptions of the care they have received. So you would expect people to be subjective, you're not looking for objective fact, you're looking for people's experience of the situation – whatever that situation is" (P9)

"We need to recognise that this is their perception so often there isn't a universal truth, there isn't black and white, there isn't a right or wrong" (P12)

In contrast to the earlier quotes, these quotes recognise the subjectivity of patient views but take very different perspectives on the value of those views. The first two examples recognise the validity of patient feedback, whilst recognising that it is based on perception and personal experience. The third and fourth staff members go further, stating that we cannot ever expect objective fact when it comes to feedback. These staff members believe that everyone has a different experience, there is no right or wrong and we must recognise this. There is a strong sense here from all of these staff that, despite their subjective and emotional nature, healthcare organisations must recognise the value of patient views, accepting them for what they are.

The way patients and the public perceive a healthcare organisation triggers within them an emotional response that determines how people engage with it. Ultimately, these perceptions can influence the success (or failure) of that organisation over time. Proactive expectation management can be the difference between a positive hospital stay and a poor experience for patients.

"It is their experience and it's their perspective of their experience so that is what is most important" (P6)

"No matter how far away somebody's feedback is from our perception of care, we treat it as something that's of value and we say what has happened, why has it happened, what is it telling us and what do we need to do about it" (P2)

Participants reported that a patient's perception of clinicians and of the healthcare system is their reality. In the following comments the interviewees highlight the importance of understanding and accepting the patient perspective on their healthcare experience.

"You have to take that at face value and accept that it is what it is for them" (P6)

"If a person is feeling a certain way about their care, then that is their own experience. We have to look at it and be balanced and measured" (P12)

When approaching an encounter with a patient, the goal for the healthcare professional typically is to make the correct diagnosis and provide an evidence-based, efficacious care.

However in the following comment the participant argues that in order to understand the patient experience, health professionals should put themselves in the position of the patient and emotionally relate to what they are feeling.

"*The only person who knows what it is like to be me is me, and I only know what it is like to be me. I don't know what it is like to be anybody else but it is beholden on me if I'm providing a service to that person to find out what it feels like to be them and what matters to them"* (P9)

A variety of perspectives have been expressed by staff regarding the legitimacy of patient feedback on their healthcare experience. Some interviewees have questioned the value of patient feedback, implicitly contrasting it with a concrete positivistic reality; highlighting it as a product of expectations, emotions and previous experience. Other interviewees accept the legitimacy of subjective patient feedback, recognising that this is the patient's perspective on what is important to them.

3.8.2 Theme 2 - The impact of patient feedback on healthcare staff

With respect to the impact that feedback from patients has on healthcare professionals, three interrelated sub-themes were identified from the participant interviews.

1. Staff welcome and value positive patient feedback

2. Negative patient feedback has a harmful emotional impact on staff

3. Patients can be reluctant to give negative feedback about their experience

I will address each of these topics in turn below.

Impact of positive feedback

Staff reported that positive affirmation helps them to feel they are getting things right and makes them more motivated to do a good job. Many of the nursing staff interviewed spoke of the encouraging and affirmative impact that positive feedback had on them. The three quotes below all mention the feeling of being 'appreciated' by patients and families.

"I think as a Senior Charge Nurse it's sometimes very comforting to get good patient feedback because you think well actually we are appreciated" (P5)

"Positive patient feedback makes me feel valued and appreciated. Receiving appreciation for your work is a great motivator, it boosts morale and makes me confident I'm doing a good job" (P11)

"Sometimes as nurses we're not good at accepting positive feedback. Accepting praise can be difficult and we often deflect compliments. Hearing it from patients and families makes me feel appreciated. It's nice to know you're doing a good job" – (P4)

From these quotes we can see that feelings of appreciation can often help reinforce a positive sense of self-worth and reminds staff what they are doing is meaningful. If staff feel that their efforts and contributions are valued by patients, then this may act as reinforcement, strengthening confidence, morale and self-esteem.

As is further evidenced in the interview quote below, frontline healthcare staff can often feel under pressure, understaffed and undervalued. However, receiving praise and recognition from patients instills pride and job satisfaction. It helps staff to positively recognise the impact of their contribution to care in the ward setting, and the wider healthcare organisation.

"I think from our perspective a lot of the time you don't think your giving those patients or their relatives the quality nursing or the time. That feedback ensures that actually we are doing a good job and these relatives were really satisfied with the palliative care side because it is very difficult to balance acute surgical with palliative care needs. So it's actually nice for the staff to think well we all work in a really busy environment and we would have liked to have done more but actually the family were happy with what care they had" – (P5)

The quote below further demonstrates how healthcare professionals perceive the visibility of positive patient feedback on social media as an important way to demonstrate to patients and the hospital management team that the staff are doing a good job.

"*lots of people use a thank you card but that is a closed system, it goes on the notice board and isn't always seen by management or leaders. Whereas if they were to use the Patient*

Opinion platform it is visible not only to the public but also to management and executives so they can see what is going on" (P12)

Interestingly the interviewees in this study made no mention of the subjective nature of feedback when patients are commenting positively on the care they receive from staff and their experience of healthcare services. Maybe not surprisingly the staff in these interviews did not question whether this positive and appreciative feedback was influenced by previous experience, expectation or emotions.

Impact of negative feedback

Whilst positive feedback can make healthcare staff feel valued and appreciated, negative feedback can be demotivating or demoralising for staff and impact on their performance. Some staff may fear receiving feedback because of its connection and potential threat to their self-confidence. The following quotes illustrate the effect of negative patient feedback on junior and senior nursing staff.

"I've experienced negative feedback from patients in my career. It often leaves you feeling defensive and demoralised" (P4)

"Some staff, especially junior colleagues, can have an awful, emotional response to negative patient feedback. It knocks your confidence and makes you question yourself " (P13)

"It's really tough and shifts can be unbearably busy. I know you'll never make everyone happy but negative comments hurt. I can fume about it for days. I feel frustrated and the comments stick with me" (P11)

It is perhaps unsurprising that critical feedback from patients can reduce clinicians' self-esteem and perceived self-efficacy, and lead to negative emotional reactions. What is not clear from the above comments however is whether the negative emotional reaction from staff will reduce their willingness to use the information to change behaviours and make improvements.

Other staff interviewed responded quite constructively and viewed negative feedback as a spur to try harder. One participant described the "profound impact" that negative feedback has on her and the "emotional connection" it brings. She regularly used patient feedback as

"a barometer for care". These comments show the effect that negative feedback can have on healthcare professionals but also the closer emotional connection it brings with the patient. Although this type of feedback does not make comfortable reading for staff, it can be used by healthcare organisations to gauge the quality of care they provide.

One participant interviewed also highlighted the emotional impact that negative patient feedback can have on staff but stressed the importance of learning from all feedback and supporting staff to deal with this.

"Negative feedback can be painful but we must try to learn from it. There are opportunities to learn from positive and negative feedback. We must support our staff to use all the feedback they receive positively." – (P15)

As healthcare organisations continue to increase their efforts on gathering feedback from patients it will be important to ensure that there are effective support systems in place for staff to deal with the emotional impact of negative feedback.

Reluctance to give negative feedback

A few interviewees felt that patients might be unwilling to provide negative or unfavourable feedback about their healthcare experience

"I do find that concerns are not necessarily always raised while the patient is here. Comments have been made like 'I didn't want to say it in case anything happened to my mother or father'. That hits me hard in the heart because you then think do you really think we would do that?" (P11)

"The majority of the comments are positive and I cannot believe for one minute that hundreds of patients have been approached on a monthly basis and we are getting 'the food is a bit samey'. There are maybe a couple of comments about the length of time for their pain killers, noise overnight and things like that but it has no meat behind it" (P11)

Patients are often so very grateful for any assistance they receive that when asked to provide feedback about the quality of care, they are reluctant to say how

they really feel. Gratitude bias can occur when feelings of gratitude for the treatment and care received by the patient causes them to be less critical of the healthcare professionals who cared for them and of the quality of care received. The response to questions about 'what could we do better?' is often met with a polite smile or a fleeting mention of some minor concern. One participant interviewed described the feedback from patients whilst still in hospital as "*not always true and honest for fear there might be negative consequences*". He described inpatients as "*hostages*" who may feel obliged to give positive feedback.

One research participant described patients as *"giving the answers they think the staff want to hear"*. Whilst another spoke of the difficulties in getting patients to open up to staff and be honest in their feedback - *"It is trying to get the members of the public to feel more comfortable with being open with us. We are happy with being open with them and it has taken a long time for us to do that as clinicians. But I think now it is about having a level playing field"* (P11).

These findings illustrate that when we have reluctance on the part of patients, families and carers to honestly express their concerns, alongside defensiveness on the part of healthcare organisations and their staff to hear and address concerns, then opportunities to learn and improve care may be lost.

Overall the comments from participants show a rather complex picture regarding the subjective nature of patient feedback and how healthcare professionals react to this. In the earlier comments from staff when they were explicitly asked to think about the value of patient feedback some commented on its subjectivity and felt this affected its validity. However when asked to think about the impact of patient feedback (positive and negative) on them personally staff spoke of the emotional impact, the subjectivity of comments was not attended to. Furthermore staff highlighted that the majority of feedback they receive is unspecific and generally positive in nature. Some interviewees suggested that this may be because patients are reticent about providing critical feedback, fearing that this might impact negatively on their future care.

3.8.3 Theme 3 – Learning from and acting on patient feedback

The quality of care provided by NHS organisations is a corporate responsibility under the leadership of boards (Patient Rights (Scotland) Act 2011). As such, boards must demonstrate that they give sufficient priority to seeking patient feedback, hearing patient stories, and taking time to listen to patients and carers. However, as discussed earlier in this chapter, the Act also requires NHS Boards in Scotland to learn from this feedback and improve patients' experiences of using health services.

An interviewee in one of the healthcare organisations felt that their Board focus more on reporting the numbers (i.e. recording and reporting the number of positive and negative comments received from patients) than actually describing how the feedback has been used for improvement.

"How do you use the findings to make improvements? That is the challenge we have got because I think we report the numbers to the board but I'm not sure that we necessarily then say how are we going to improve things and prove our improvements have made a difference" (P14)

There was a similar viewpoint from the participants in a different healthcare organisation who both felt that their board were predominantly focused on the quantitative feedback data rather than how it is used to inform improvement and re-design of services.

"The Board do need cross-organisational data on patient experience but I think there is potential that the individual patient story gets lost when this feedback is aggregated up into quantifiable data. We shouldn't be collecting it just for Board assurance purposes, it has got to be for driving improvement" (P8)

"Patient feedback is being used by leadership to generate numerical data for board governance purposes rather than seeing the person and their personal story – that is a challenge. All qualitative information collected, including feedback, is ultimately turned into numerical data" (P12)

The board in NHS organisations have an overall governance role and clearly cannot have sight of all patient feedback. However, these comments from interviewees suggest that by

focusing on patient feedback numbers, rather than the stories behind them, the board is losing the richer narrative for understanding how services can be improved. There is a challenge here for healthcare organisations in demonstrating learning and improvement to their governance board rather than just providing assurance on activity.

A participant in one site described her work with board members to build an understanding of the broad range of work on learning from patient feedback. She described the importance of buy-in from non-executive directors and explained that currently "*not everyone is in the same place in how feedback is used*" (P1)

"The Chairman is supportive but challenging when areas for improvement are identified from feedback. If bad practice exists you call it out and deal with it. We are not going to be an organisation who have a love-in every day about this" (P1)

In one healthcare organisation the participant described a supportive patient focused culture where the board members prioritise patient feedback alongside the other more traditional quality indicators. In this organisation "*every Board meeting starts with a patient story and the first papers for discussion are quality, safety & patient experience*". These patient stories reveal a great deal about the quality of services, the culture of the organisation, and the effectiveness of mechanisms to manage, improve and assure quality. They also serve as a powerful reminder to executive and non-executive members of their accountability for quality. Permission is sought from the patient to have their patient story presented at a Board meeting and the participant said that families have informed her "*having the knowledge their story has been shared with management has provided closure and gives reassurance that staff have gained learning*."

There is a difference here in how each of the healthcare organisations prioritise learning from patient feedback to bring about change and improvement. More work needs to be done with board members to build and embed a culture of valuing feedback and in ensuring that learning from feedback is embedded in their organisation.

Interviews with staff showed that there is variation in whether patient feedback is used to inform improvement, not just across the three healthcare organisations, but also within departments and teams in individual sites. One participant suggested that the degree to

which patient feedback is understood, analysed and acted upon "*varies greatly and depends on the extent to which the team have embraced quality improvement*". This was echoed by a participant in another NHS Board who highlighted the patchy nature of improvements based on feedback from patients:

"Improvements through patient feedback are happening in some areas but it is not universal. We have definitely got it in spots but it's not happening across all wards and teams" (P1)

Staff interviewed in each of the three healthcare organisations were able to provide examples of improvements that had been made following feedback from patients. These improvements included environmental modifications, updates to patient information, better patient communication and engagement, changes to diet and treatment. The following specific improvements have all been made following patient feedback across the three healthcare organisations in this study:

- Changes were made to the layout of the urology out-patient waiting area in one board area to make it more private for patients waiting in gowns

- Feedback from patients highlighted that the fixed seating in the ophthalmology outpatient clinic was negative and unsociable as it determined the way patients face and limited opportunities to talk. Movable seats were introduced to enable patients to choose what suits them.

- Patient appointment letters in the Gastroenterology Unit were updated to include clearer information regarding pre-operative fasting instructions and advice.

- Feedback from the husband of a patient identified the limited special diet that was available for his wife who is neurologically compromised. This was discussed at the Food, Fluid and Nutrition Group and, as a result of this feedback; four new items were added to the special diet list.

- Following feedback from patients, focus groups were established for patients who have undergone colorectal surgery. This resulted in a change to the enhanced recovery pathway for colorectal surgery. Furthermore all patient information was revisited and improved, following feedback from patients.
- Alarm clocks were introduced in inpatient areas as a medication reminder for Parkinson's patients
- Nursing staff on the Medical Ward have introduced extra snacks and drinks following feedback from patients with diabetes

By using patient feedback to inform improvement, healthcare providers are demonstrating two key beliefs. First, they are reaffirming that patients' views are valid, legitimate and important elements in evaluating quality of care. Second, they are establishing that sharing such feedback is good for both the healthcare professionals and the patients who use their services.

3.9 Contributions to Knowledge

Whilst there are some published studies that have sought the views of frontline clinicians and patients on the use of online patient feedback, this research brings a new understanding of the perceptions and attitudes of senior healthcare managers on this topic, and draws on interviews with medical and nurse directors, patient experience, quality improvement and communications managers. This is the group of staff who set policy and strategy for patient experience and engagement in their healthcare organisation. It is the perceptions and attitudes of these senior healthcare managers that can ultimately influence the actions and behaviours of frontline staff.

The findings from this study show that senior healthcare managers are concerned about the potential impact of negative online patient feedback on personal and organisational reputation. Patient feedback that is highly critical of their practice can cause healthcare professionals significant stress and may lead to physical and psychological symptoms. Healthcare organisations need a more systematic approach to supporting staff to deal with negative patient feedback. Both structural and process interventions are needed at

individual, team and organisational level to build a supportive culture where all patient feedback is welcomed and seen as an opportunity to learn and improve. This means moving away from a name, blame and shame culture to one that is non-punitive, compassionate and collaborative.

Senior healthcare managers did not question whether *positive* patient feedback is influenced by previous experience, expectations or emotions. This very selective questioning of subjectivity may show certain biases in how the online patient feedback is received by senior managers, thus accepting what they want from feedback whilst ignoring or refuting negative viewpoints that are inconsistent with their own perceptions.

The findings from this research study show a difference in how healthcare organisations prioritise learning from patient feedback to bring about change and improvement. Senior healthcare managers are concerned that patient feedback is predominantly being used by the NHS board for assurance purposes rather than to generate commitment to change, and to support the design and implementation of specific improvements. More work needs to be done with board members and senior managers in healthcare organisations to build, embed and transmit a culture of valuing all patient feedback, ensuring that any learning from this feedback is embedded within healthcare organisations.

3.10 Conclusions

In this chapter I set out to explore senior healthcare managers' views on the validity and value of patient feedback, and whether this feedback could be used to inform improvements to healthcare services. Conclusions have been drawn from a review of the published research literature and an analysis of participant interviews. The process of analysis and interpretation from the interview transcripts through to the final findings was explained, and critically discussed in the Methods Chapter.

The research shows that patient experience is strongly linked to patient expectations (Tahir 2012). Every patient will have their own desires or predictions about what to expect from the clinician and the healthcare organisation. These expectations are complex and often

dependent on factors like previous experience, desires or hopes (Bowling et al 2012). In the interviews for this study, a number of participants reported that it is important for professionals to understand the individual expectations underlying patients' experiences in order to interpret their feedback. It was noted by some interviewees that patient expectations can sometimes be unrealistic and cannot always be met. Addressing this dissonance between patient expectation and patient experience can be challenging for healthcare professionals. When a patient's needs and expectations for care clash, there is an 'expectation gap' (Kvamme et al. 2001). This gap can be narrowed or closed by providing appropriate and timely information for the patient and by maintaining dialogue between the healthcare professionals. Shared decision-making is where clinicians and patients make decisions together, and is a widely regarded approach for patient communication (Charles et al. 1999). Through shared decision making patients are encouraged to engage with the healthcare process and consider the options to treat or manage their condition (and the likely benefits and harms of each) so that they can help select the best course of action. Shared decision-making, starting from the patient's expectations/goals and involving the patient and other healthcare professionals, can reduce the expectation gap and encourage empowerment of the patient.

Patients and carers arriving at healthcare organisations will inevitably arrive with certain expectations. However, the initial direct interaction between healthcare professional and patient will strongly shape the experiences and emotions that will follow. When this initial moment of interaction goes well, a positive cycle begins between the patient and the healthcare organisation. When this initial interaction goes poorly, it can be hard to recover. Creating a culture of first impressions within the organisation can help keep patient experience positive.

A broad awareness of patient expectations, met and unmet, among healthcare professionals will enable them to better understand the patients' perspective and to manage these expectations realistically so that patients do not feel frustrated. Healthcare organisations should put in place strategies for training healthcare professionals to elicit patients' values and expectations, and engage them in shared decisions about their care.

In line with the published research (Sitzia & Wood 1998; Chapple et al. 2002; Marcinowicz et al. 2009; Boiko et al. 2015) there were contrasting views from the interviewees as to whether patients can judge the quality of their own care. Most of the participants in this study considered patient feedback to be a highly subjective set of thoughts informed by a wide range of influences, such as previous experience, inner fears, and expectations. However staff expressed two differing perspectives regarding the validity and value of this subjective patient feedback. Some interviewees regarded the feedback as valid and legitimate, believing it to reflect what is important to the patient. As such, they are uniquely placed and motivated to contribute to improving the quality of their own care (Ward & Armitage 2012). Other participants questioned the usefulness and value of this feedback, reporting that it isn't as valid as the objective clinical measures. When considering patient feedback, healthcare organisations should consider the objective reality of the service alongside the patients' subjective perceptions and expectation around that service.

Interestingly, and perhaps unsurprising, staff were more accepting of the subjective nature of patient feedback when this was positive in nature. Interviewees only mentioned the subjectivity of patient feedback when this was critical of staff or the organisation. There is a risk here that by dismissing the feedback as subjective, unfair or untrue, the staff might miss what the patient is trying to tell them.

Staff reported that much of the feedback they receive from patients can be quite general and is most often positive in nature. The research shows that positive feedback empowers staff, helping them feel appreciated and valued by patients (Tasa et al. 1996). This was also evident in the comments from interviewees, many of whom commented on the encouraging and affirmative impact that positive feedback had on them. Only a small amount of patient feedback is negative or critical of their healthcare experience. Some interviewees suggested that patients might be unwilling to provide critical feedback, as they are concerned it could impact on their future care or relationship with staff. When they do receive critical feedback from patients, staff commented that this often has a demotivating or demoralising effect on those involved. It is essential that healthcare organisations support their staff to feel safe in obtaining feedback, to resist the understandable urge to be defensive, and to give them the skills to drive the required improvements. This will take a

sustained effort over time by reinforcing value-driven behaviours that align to person-centred care. Further work is required to understand more about the perceived barriers to patients providing negative feedback and the resistance to receiving negative feedback on the part of some healthcare staff.

Patient experience is complex and multidimensional; it involves clinical, transactional and interpersonal aspects of care (Zinckernagel et al. 2017). Some staff commented that the patient feedback in their organisation is reduced to numbers (positive and negative) when reported to their governance board. There was concern from these interviewees that the rich personal narrative was missing from this reporting and that patient feedback was only being used for assurance purposes rather than to generate commitment to change and to support the design and implementation of specific improvements. The literature suggest that patient feedback cannot be reduced to a single metric to judge performance (Churchill & Evans 2013) but instead should be used by board members and senior management to understand what the local community feels about their healthcare service (Mercer et al. 2007). Given the increasing recognition of the importance of listening to patient feedback (Sheard et al. 2017; Sheard et al. 2019) the comments from interviewees in this study suggest that board members and senior management are moving too slowly in response to how frontline clinical staff would like to use feedback. Boards should consider how they currently use patient feedback, to ensure that information and discussions lead to actions and decisions to both assure and improve the quality of healthcare services.

The conventional approach to analysis and classification of patient feedback is to group this information into 'positive' and 'negative' comments regarding the quality of health and care services. However it might be more helpful to healthcare organisations and professionals to reconfigure what they mean by 'positive' and 'negative' in this context. It can be argued that the value of patient feedback is directly related to how actionable it is. By categorising the feedback from patients as 'positive' when it provides clear information that is diagnostic of action, the concerns about subjectivity would be removed and the value of the feedback would now be based on an assessment of whether the feedback provides helpful information regarding the actions that could be taken to support improvement.

The more traditional paper based methods for capturing patient feedback are increasingly being complemented by feedback received through social networking tools. In the next chapter I will examine the role of social media in capturing patient feedback, measuring its effectiveness and considering opportunities for the future.

4. Using Social Media as Patient Feedback

4.1 Introduction

A series of interviews was carried out with senior healthcare managers from three NHS Health Boards in Scotland to explore the following research question:

What are senior healthcare managers' perspectives of using social media patient feedback to improve care?

In this chapter I will focus specifically on senior healthcare managers' perceptions of the legitimacy of social media as a source of patient feedback and what they see as the main benefits and barriers to using social media feedback for improvements to care.

Before reporting the results from participant interviews I will critically review the relevant research literature regarding; how we define social media; what online methods are used for patient feedback; what are the benefits and challenges to using social media patient feedback for improvement; and how do we measure the impact and effectiveness of social media for patient engagement.

4.2 Defining Social Media

Often referred to interchangeably as Web 2.0‖(Giustini 2006), consumer-generated media‖(Gretzel et al. 2008) or user- generated information systems (DesAutels 2011), there is no single universally agreed definition of social media ((Carr & Hayes 2015; Effing et al. 2011). Some definitions are relatively simple, for example Russo et al. (2008) define social media as "those that facilitate online communication, networking, and/or collaboration". A more comprehensive definition of social media is offered by Solis (2007), who said that it is "the democratization of information, transforming people from content readers into publishers. It is the shift from a broadcast mechanism, one-to-many, to a many-to-many model, rooted in conversations between authors, people, and peers". This second definition highlights the ability for many-to-many communication made possible by social media,

compared to previous analogue technologies in which the medium would typically allow one to one communication, for example the telephone. Social media allows people to connect and communicate dynamically.

At this point it is helpful to separate and unpack the two elements of 'social' and 'media'. One popular characterisation of social media comes from Kaplan & Haenlein (2010) who define it as "a group of Internet-based applications that build on the ideological and technological foundations of Web 2.0, and that allow the creation and exchange of User Generated Content". Whilst this definition encompasses the 'media' element of social media i.e. generation of content, the 'social' part of the definition is made only implicitly through references to "Web 2.0" and "User Generated Content". Ahlqvist et al. (2008) focus more on the 'social' nature of social media, describing it as "a means of interactions among people in which they create, share, and exchange information and ideas in virtual communities and networks". Likewise LaRose et al. (2014) emphasise the social and interactive nature of this medium "used to form or maintain social relationships through creation and exchange of electronic interpersonal communication". It is the blend of technology and social interaction that gives social media its unique value proposition.

Social media networks have distinctive features that encourage users to engage in information sharing (Paroutis & Al Saleh 2009) and interacting with others (Hansen et al. 2012). Tuten & Solomon (2013) describe this interconnected / interdependent nature of social media as an online means of "communication, conveyance, collaboration and cultivation". Similarly Henderson & Bowley (2010) define social media as "collaborative online applications and technologies that enable participation, connectivity, user-generated content, sharing of information, and collaboration amongst a community of users". One defining characteristic in both of these definitions is the potential for social media to facilitate the interactive communication and collaboration among numerous participants via technology.

It is this ability to connect with others, share information, create, and engage with the community that, in theory at least, make social media potentially suitable for communication and connection between patients and healthcare staff. In the section that

follows I will discuss and critically evaluate the use of social media patient feedback by senior healthcare managers to inform quality improvement.

4.3 Capturing patient experience through social media

Historically, patient feedback on their healthcare experience has been captured on paper rather than in a digital format (Greaves et al. 2013b). These traditional measures of patient experience, such as questionnaires or surveys, often ask limited questions (Loeb 2004), are generally conducted infrequently (Reeves & Seccombe 2008), and can be expensive to administer (Greaves et al. 2013b). Furthermore conventional methods of collecting feedback also have limitations based on sensitivity to change in longitudinal observational studies, and intra-individual variations over time (Kvien & Heiberg 2003). These difficulties are pushing many healthcare organisations to consider other methods and mediums for capturing patient feedback.

The internet is changing the way in which patients and the public experience health and illness (Ziebland 2012). The paper-based methods for capturing patient feedback are increasingly being augmented by spontaneous sharing through online social networking tools (Mazanderani & Powell 2013). Social media is more and more being seen as a "source of data for surveillance and research" (McKee 2013), for example by tracking concerns or capturing conversations taking place outside traditional media outlets. Healthcare organisations are beginning to use social media platforms to understand what patients are saying about their care (Hawkins et al. 2015; Greaves et al. 2014), for example reviewing and analysing comments left on structured patient feedback websites (e.g. NHS Choices and Care Opinion) (Lupton 2014) and also unstructured and unsolicited narratives about treatment, health services and illness in online settings such as blogs (Chou et al. 2009), fora (Perales et al. 2016) and social networking sites (Hackworth & Kunz 2011). All of these social media tools share characteristics with the more traditional methods of assessment that allow individuals to comment on their current activity, location, and social surroundings at any particular moment (Yoon et al. 2013). However, unlike the more traditional assessment methods, social media comments and feedback are made in a more naturalistic setting and not dependent on a specific stimulus to the intended respondent (De Choudhury et al.

2013). Greaves et al. (2013) describe this vast source of unfiltered online information about the quality of healthcare as “the cloud of patient experience”. The advent of these new communication technologies potentially opens the door to real time patient feedback that is unfiltered by traditional methods of data capture and analysis. Rozenblum & Bates (2013) suggest, ‘healthcare, social media and the Internet – are beginning to come together … and have the potential to create a major shift in how patients and healthcare organisations connect’. This is stated yet more strongly by Thielst (2011) who claims that the ‘ubiquitous nature of social media creates opportunities for true patient-centred care’.

Much of the published research in this area relates to the analyses of patient reviews on US physician rating websites (Holliday et al. 2017; Daskivich et al. 2018; Rothenfluh & Schulz 2017; Rothenfluh & Schulz 2018). These websites provide an online method for patients to rate and discuss their encounters and experiences with clinicians. Their structure is similar to other Internet-based rating systems that combine public reporting with social networking, such as the travel website Trip Advisor (Lagu et al. 2010). There are however only a limited number of studies published in open source literature that specifically explore and evaluate the use of social media patient feedback by healthcare organisations and professionals to inform improvement to care and services. I have split my review of published research regarding online patient feedback into two areas:

1. Patient feedback that is provided through a dedicated website such as Care Opinion and NHS Choices
2. Patient feedback that is provided through micro-blogging and social network tools such as Twitter and Facebook

4.3.1 Patient Feedback Websites

Dudhwala et al. (2017) use the term SSS (sanctioned, solicited, sought) to identify online feedback that is actively sought by healthcare organisations. Here patients are encouraged to give feedback through a designated approved online medium, for example Care Opinion. This patient feedback is then used to assess and understand the experience of patients. In

contrast, UUU (unsanctioned, unsolicited, unsought) online feedback is that which patients leave without any prior prompting or solicitation, for example through Twitter and Facebook. Healthcare organisations may have neither the resources nor the ability to deal with these multiple sources of feedback.

Care Opinion Website

Care Opinion (formerly Patient Opinion, the website changed its name on 1 May 2017) is an online feedback tool for patients in the United Kingdom. In Scotland it is funded and endorsed by the Scottish Government for people to share their stories and experiences of health and care services. All Health Boards in Scotland use Care Opinion at some level (Care Opinion 2015). Care Opinion is an independent website that allows patients to submit stories regarding their experience of health and social care services as a patient, service user or carer. Once submitted, the story is moderated by Care Opinion staff and published on their website. No patient identifiable information is published on the website. Once a story is published on the website, staff in the relevant organisation are alerted by email so that they may read, respond and make improvements if necessary. Healthcare organisations can indicate on the website whether a change is planned, or has already been made in response to a patient story. The notification of a planned or implemented change is made by the responder from the healthcare organisation rather than by Care Opinion staff (Baines et al. 2018). During 2017/18 there were 3207 stories shared by patients, service users and carers regarding healthcare services in NHS Scotland, this is a 145% rise in stories shared since March 2015 (Care Opinion 2018a). The majority of patient feedback on Care Opinion is of a positive nature (67% of stories are positive, sharing thanks and appreciation). Only 66 (2%) of patient stories in 2017/18 resulted in change or change being planned (Care Opinion 2018a).

Ponsignon et al. (2015) analysed 200 cancer patient stories published on the Patient Opinion website in the UK. Using content analysis the authors categorised and described 22 main categories that underlie the patient experience in healthcare. The study identifies what constitutes positive and negative healthcare experiences and provides insight into areas that are perceived as particularly problematic by patients and carers, including a lack of

explanation, expertise and focus on patient needs (i.e. direct interactions) as well as issues regarding staffing levels, administration processes, internal communication, amenities and maintenance. Where social media tools like Twitter have character limitations that seriously limit the level of detail and context in patient feedback, the authors in this study assert that dedicated feedback websites like Patient Opinion provide the means for a "rich detailed understanding of the healthcare experience". The authors conclude that Healthcare organisations and professionals can use patient stories posted on the Care Opinion website to identify problematic areas from the patient perspective and trigger improvements in the service delivery system. For example, a hospital could identify underdeveloped aspects of the healthcare experience and formulate redesign guidelines that directly affect patient perceptions.

In a similar study Schembri (2015) undertook a narrative analysis of 300 patient stories of healthcare service experiences in Australia. This collection of patient stories was drawn from publicly available information published by www.patientopinion.org.au. From this sample of stories narrative analysis was used to identify and describe the patients' experience of healthcare service quality. What is evident from the findings in this study is that there is a complexity and layered depth to the patient stories that cannot be captured by simple measures of patient satisfaction. The patients' stories included information on both the functional quality of the service they experience and the technical quality of the service they experience. The authors concluded that there is value for healthcare organisations in considering healthcare service quality through the patients' eyes and suggest that stories on the Patient Opinion website can provide strategic insight into improving the quality of service they provide outside the realm of objective satisfaction measures.

Baines et al. (2018) sought to identify those factors considered potentially helpful in enhancing the quality of response to online patient feedback by healthcare organisations. The authors chose to focus on responses to adult mental health stories posted on the Patient Opinion website in the UK. Mental health was chosen as this is often reported as one of the most problematic areas to obtain and respond to patient feedback due to acknowledged trust issues and low response rates. A total of 245 stories were identified, with 183 (74.7%) receiving a response. However only 1.6% (n = 4/245) were tagged by the

organisation as “may lead to a change.” What was not clear is whether being labelled by the organisation in this way is attributed to problems in data collection methods, for example detail specificity, or is it attributable to wider professional and organisational cultural issues that inhibit patient feedback acceptance and subsequent action. The authors developed a best practice response framework for healthcare organisations to enhance response quality and subsequent quality improvement initiatives. The proposed framework identifies the key factors considered influential in providing an effective organisational response to patient feedback in an online environment. These are: introduce the responder, provide an explanation of their role, offer thanks and apologies where appropriate, respond within seven days, and provide a uniquely tailored response.

NHS Choices Website

NHS Choices is a government-run website that provides information to support self-care and captures patient feedback for all NHS trusts and hospitals in England and Wales (NHS 2018). Members of the public can leave free-text feedback and rate how likely they are to recommend the organisation to friends or family in need of similar care. Like the Care Opinion website, patient feedback is actively moderated before being displayed with any references to individuals and speculation removed. When a comment is approved and posted on NHS Choices, a nominated contact at the relevant healthcare organisation is alerted by email and has the opportunity to post a response.

A large study by Brookes & Baker (2017) examined 228 113 comments of online patient feedback posted to the NHS Choices website in the UK between March 2013 and September 2015. Using content analysis techniques to analyse the feedback, four areas emerged as frequent themes across the comments: (1) treatment (*care*, *treatment*); (2) communication (*communication*, *attention*, *and advice*); (3) interpersonal skills (*atmosphere*, *attitude* and *manner*) and (4) system/organisation (*system*, *appointment*, *management* and *waiting times*). Overall, NHS services were evaluated positively by patients three times more than negatively. The most common themes from positive feedback related to staff being caring, compassionate and knowing patients’ names. Rudeness, apathy and not listening were identified as the most frequent drivers of negative feedback

Although the authors suggest that the reported drivers of negative and positive feedback offer insight that can be used to stimulate and guide quality improvement efforts, there is no evidence of this and the scope of the study did not extend to examining how the patient feedback on NHS Choices was used by healthcare organisations. Furthermore, the authors did not examine the demographic data as part of their analysis of online feedback and were therefore unable to determine whether feedback came from patients living in certain locations or belonging to particular age, ethnic or sex-related groups. This segmentation is important in helping to understand whether particular concerns are attributable to specific patient groups or locations, and may have offered insights that were missed by only looking at the aggregate data.

One of the first published studies exploring the potential of online patient feedback to inform the quality of healthcare was undertaken in the UK by Greaves et al. (2013b). The researchers applied machine learning techniques to 6412 online comments about hospitals on the English National Health Service website (NHS Choices) in 2010. Sentiment analysis techniques were used to categorise the free text comments left by patients as either positive or negative descriptions of their care. The results from this sentiment analysis were then compared with the paper-based national inpatient survey results, an annual national survey of randomly selected patients admitted to NHS hospitals in England, using Spearman rank correlation. In this study the authors only used questions from the national inpatient survey that were similar to specific themes identified from the NHS Choices data – (i) cleanliness, (ii) respect and dignity, and (iii) overall rating of care. There was an 81%, 84% and 89% agreement respectively between the paper-based survey and those derived from the online free text comments for cleanliness, treated with dignity, and overall recommendation of hospital. The results from this study suggest that online patient comments are associated with patient experience results from traditional paper based surveys. Furthermore, these results suggest that patient feedback websites, in which people describe their care, may be an important avenue for understanding patient experience, and could provide an additional source of near real time information on the care experience to complement the national patient survey, which is only undertaken annually.

In this section I considered the published literature regarding patient feedback that has been captured through the dedicated patient websites NHS Choices and Care Opinion. In the next section I will critically review the research literature regarding the use of social networking tools like Facebook and Twitter to capture patient feedback.

4.3.2 Social Networking Tools

In a large study by Hawkins et al. (2016) the researchers used machine learning to study over 400,000 tweets directed to 2349 hospitals in the United States. In contrast to Greaves et al. (2013b) the authors found that, with the exception of a weak association with 30-day hospital readmission rates, Twitter sentiment was not associated with the established standard measure of patient experience in the US (Hospital Consumer Assessment of Healthcare Providers and Systems ratings). Like Greaves et al. (2013b) and Brookes & Baker (2017) the authors in this study suggest that the near realtime nature of online feedback may provide a useful supplementary data stream to complement the traditional approaches of assessing quality of care. However the findings from this study suggest that Twitter sentiment must be treated with caution in understanding the patient experience. Timely information will be of little use if it does not reflect the quality of care. Given the lack of association in this study between Twitter feedback and established patient experience measures it is not clear how valid this unsolicited type of patient feedback is.

A small-scale study by Lagu et al. (2016) reviewed patient feedback on the Western Massachusetts Hospital Facebook page over a 3-week period. In contrast to Twitter, Facebook does not have an enforced character limit and patients can provide more detailed narratives using this medium. Analysis of all posts during this period identified several broad themes in the Facebook comments relating to staff, specific departments and technical aspects of care. Positive feedback from patients included descriptions of staff efficiency, caring behaviour and good communication, whereas negative comments included descriptions of unfriendliness, inattentiveness, poor training, and unprofessional behaviour. The insights gained from the solicited Facebook feedback are similar to the feedback received through traditional survey methods and none of the areas identified for improvement were considered novel quality improvement targets for the hospital. Whilst it

is clear that this study has some limitations; a short study period in a single centre involving one social media platform (Facebook), the authors suggest that engaging with patients in a public space like Facebook increases the likelihood that healthcare organisations will attempt to improve care in response. There is however no evidence that one will lead to the other and to conclude that patient feedback on Facebook can drive hospital quality improvement is unwarranted.

Focusing on social media feedback from a specific patient group, Shepherd et al. (2015) considered the potential role of Twitter for the provision of feedback on mental health service user experience. In a qualitative analysis over 500 tweets were reviewed and grouped into four overarching thematic headings: impact of diagnosis on personal identity and as a facilitator for accessing care; balance of power between professional and service user; therapeutic relationship and developing professional communication; and support provision through medication and service provision. The authors state that the themes identified from tweets are those that researchers were already aware of in the academic literature (Bracken et al. 2012; Morrison et al. 2012), which possibly questions what added value there is to be gathered from this type of analysis. However an alternative view might be that, in this instance at least, analysis of social media feedback provides a cost-effective alternative to expensive research studies. Much of the social media feedback in this study was concrete in nature, with patients discussing positive and negative aspects of their care experience. The authors hypothesise that that social media could provide a resource through which some of the barriers traditionally encountered by users of mental health services, such as societal stigma and mistrust in the system can be overcome. Although this study shows that Twitter may provide a discursive online space for patients to talk about their condition, the data collection method used means that there is no assurance that the collected tweets were posted by patients with mental health issues. Furthermore the study does not demonstrate whether any behavioural or operational changes have arisen resulting from participation by either mental health patients or health professionals. Interestingly the authors' decision to exclude other more detailed sources such as patient feedback websites, blogs and fora potentially misses out on the depth and breadth of content that a discussion such as this encompasses. This suggests that further

research is required into what are the best social media tools and platforms to gather and review patient views on their care experience.

The evidence reviewed here seems to suggest that social media could be useful as a medium for patients to post feedback online and discuss, reflect and share issues regarding their care experience with other patients or healthcare professionals. However the evidence is mixed and sometimes conflicting, with one large study by Hawkins et al. (2016) showing no association with the established measures of patient experience and another by Greaves et al. (2013b) showing close agreement with the results from a National Inpatient Survey. Some studies looked at the use of dedicated websites to collect patient feedback, whilst others have used machine learning sentiment analysis tools to extract the common themes from vast numbers of online comments on Twitter and Facebook. From this analysis, most of the study authors have gone on to conclude that by posting feedback online this information can then be used by to make improvements to health and care services. However this seems to be an assumption on the part of the researchers and there is no evidence provided in these studies to demonstrate that sharing patient experience information on social media will lead to a healthcare organisation changing and improving health and care services.

Unstructured patient feedback from micro-blogging sites such as Twitter will not always contain sufficient detail for healthcare organisations to identify the concern and make improvements (Atherton et al. 2019). Nor will patients always include details of the hospital, unit or ward where they have received care. Dedicated patient feedback websites like Care Opinion and NHS Choices may provide the functionality for patients to make full and detailed feedback about their care experience. In theory at least, this level of detail is more helpful in providing more information for the healthcare organisation to act on and make improvements.

Some healthcare professionals have raised concern that patient feedback on social media will merely provide a vehicle for disgruntled patients to vent frustration over minor shortcomings, and that this feedback could impact on a clinician's reputation (McCartney 2009; Jain 2010). However in the UK the percentage of patient stories on the Care Opinion website that include positive feedback from the public has increased from 47% in 2015 to

72% in 2018 (Scottish Government 2019). These stories often focus on the very human elements of healthcare, for example communication, compassion and collaboration (Care Opinion 2017). Positive stories can provide helpful feedback for staff on what is working well and could be implemented elsewhere. Furthermore, positive patient feedback also reinforces positive behaviours and provides encouragement and support to healthcare professionals (Mylod & Lee 2015). This is important, as positive patient feedback is essential in building trust in websites like Care Opinion, and may show healthcare staff that these feedback websites are not simply an easy way for patients to criticise or complain.

These social media tools have given patients a virtual platform of unprecedented reach and influence for publicly sharing their experience of healthcare services. However, whilst there is increasing evidence of the potential for social media to educate, empower and engage patients, there are a number of organisational, cultural, technical, and knowledge barriers that can hinder its use by healthcare organisations and professionals to inform improvement. In the next section I will describe some of the benefits and challenges with regard to the adoption of social media as a means for capturing patient feedback.

4.4 Benefits and challenges of using social media patient feedback for improvement

Hailed by some as a means of enabling participative democratic patient engagement, online feedback raises a number of new and complex issues (Speed et al. 2016; Wyatt et al. 2013). The published literature regarding the usefulness of online patient feedback reflects a set of contrasting opinions regarding its value and effectiveness. Some focus on what they regard as the benefits of this medium over the more traditional feedback methods – its real time nature (Platt & Hood 2012), ease of access for patients (Hackworth & Kunz 2011), relatively lower costs (Hunt et al. 2015), ability to reach seldom heard groups (Wong et al. 2014), and enabling patients to vocalise the often hidden aspects of how they experience the clinical encounter and care provision (Lagu et al. 2016). However there are others who are more sceptical, arguing that social media is not an appropriate avenue to communicate patient

feedback (Patel et al. 2015), or that those contributions being made online are not relevant (Schlesinger et al. 2015). Currently, only a minority of users offer feedback about their healthcare experiences online, raising questions by some about representativeness and the potential for bias (Powell et al. 2015; Kordzadeh 2019; Point of Care Foundation 2019).

In the following sections I will explore some of the benefits and the challenges in using social media patient feedback for improvement in healthcare organisations.

4.4.1 Anonymity of online patient feedback

Those arguing against the use of patient feedback captured through social media often draw attention to the practical difficulties and the opportunities for misuse (Greaves et al. 2014; Patel et al. 2015). Speed et al. (2016) have identified this as the anonymity/vulnerability paradox, affecting both patients and health professionals. While anonymity may make patients feel less vulnerable to possible negative sanction, it can make healthcare professionals feel more vulnerable, particularly when this feedback is publically available (Patel et al. 2015). The impersonal nature of social media could allow patients to more comfortably give feedback about the staff who care for them, whilst minimising any social desirability effects (Bowling 2005). In theory it could diminish the usual power dynamics between health professionals and patients and offer honest critique without patients fearing negative consequences on their care (Joseph-Williams et al. 2014; Speed et al. 2016).

The lack of opportunity to feedback anonymously has been recognised as a flaw in the current NHS complaints process (Parliamentary and Health Service Ombudsman 2014). In Scotland, the issue of anonymity has been addressed to a certain extent through the adoption of Care Opinion (Care Opinion 2018a) by all NHS boards as the recognised platform for online patient feedback (Tevendale; 2015). Patients posting stories on the Care Opinion website are required to provide an email address and the feedback is moderated by Care Opinion Staff to remove offensive material, potential identifying content and fictitious/untrue stories. However, this does mean that patients must trust in Care Opinion to exercise balanced moderation and good judgement. There is limited published research to date into the use of Care Opinion (Ponsignon et al. 2015; Schembri 2015; Ziewitz 2017;

Baines et al. 2018) and further work is needed to understand the attitudes and motivations of users of this online tool. Furthermore an analysis of the 'changes made' recorded on the Care Opinion website, how these decisions have been informed by Care Opinion patient stories and how this information is reported to 'decision makers' would be helpful for healthcare organisations to understand how to increase the impact of this online tool.

4.4.2 Real time patient feedback

There is often a time lag with getting the results from paper-based patient feedback surveys and questionnaires. For example, the Scottish Inpatient Experience Survey has an approximately 1-year delay between the instrument's use and results being published (Scottish Government 2018). The real time nature of social media can increase the chances of feedback being put to effective use as staff recognise the 'freshness' of the information and perceive it as having greater validity (Brown 2009). In comparison to the traditional paper based surveys and questionnaires, the immediacy of real time feedback helps to offset feedback fatigue (Carter et al. 2016) and feelings of remoteness from the feedback process. Real time online feedback brings the patient experience to life and adds a sense of urgency for healthcare professionals to make improvements (Käsbauer et al. 2017). A further benefit of social media is that patients can leave feedback at a time and place of their choosing (Dudhwala et al. 2017). They may be waiting in outpatients, posting the second or third patient story on their inpatient stay, or they might take time to reflect and comment from home after being discharged.

Timely feedback from patients about their healthcare experience could allow healthcare organisations to understand the system performance in close to real time with the potential to act as an early warning for poor clinical care (Greaves et al. 2013b). However healthcare organisations will have to weigh the benefits of real time feedback against the likelihood that patients will also want and expect a quick response to their online feedback. This can sometimes be difficult for frontline staff who may have limited time available to engage with the results of realtime feedback and often won't have access to a computer as part of their regular duties (Käsbauer et al. 2017). This raises the question of who has 'ownership' and 'authority' within the organisation to review and respond to online patient feedback. Recognising there will be training requirements and resource implications, as the numbers

of patient feedback using social media increases, it will be important to have multiple responders across multiple disciplines and specialties within the healthcare organisation, and not create a bottleneck by limiting responders to a few individuals within the administrative team. In the next section I will consider the open nature of social media patient feedback and the requirement that this brings for transparency in public discourse, responding to comments and sharing progress.

4.4.3 Openness and Transparency

Those who advocate for social media as the future for capturing patient feedback often cite the openness, transparency, and informality as a benefit of these online tools (Gholami-Kordkheili et al. 2013). In the context of patient feedback, transparency can be interpreted as the healthcare organisation opening out to the public and subjecting the work of healthcare professionals to scrutiny from the outside (Levay & Waks 2009). One of the key differences between social media feedback and paper-based methods is that the response from the healthcare organisation to patient comments is available for all to see. It is important to make the distinction here between organisations responding merely to acknowledge receipt of the patient feedback and a response identifying that changes have been made or planned as a result of the feedback. Through open online patient feedback websites like Care Opinion, healthcare organisations have the opportunity to demonstrate that staff have read the patient story, provided a public response in near real time, and, if required, documented change that brings about service improvement. Research has shown that when patients perceive their healthcare organisation as open, transparent and engaging, they have a more positive perception of the care they receive (Bacon 2009). It is possible that this transparency online may help to mitigate any reputational issues arising from negative patient feedback and help healthcare organisations to demonstrate a willingness to learn from patient feedback. However, it is important to note that the changes described on Care Opinion are self-reported by the responder in the healthcare organisation and not by Care Opinion. As noted earlier, the majority of patient stories posted on Care Opinion are positive and as such will not necessarily require that a change be made. The public nature of feedback sites such as Care Opinion and NHS Choices enables healthcare organisations to manage the online feedback locally whilst understanding that

other patients and carers may also be reading the patient story online (Adams 2011). Patient feedback on social media is also open to examination by healthcare regulators in the UK. The Care Quality Commission in England track patient feedback from NHS Choices, Care Opinion, Facebook and Twitter to identify high-risk organisations for inspection (Griffiths & Leaver 2018).

4.4.4 Age and Information Technology Skills

In this section I will consider age and technology skills of the patient as a potential barrier to providing feedback through social media. Despite digital society's apparent pervasiveness, not everyone is digitally connected (Office for National Statistics 2018). The 'digital divide,' a social and economic divide that restricts access to information and communication technology, is a potential barrier to some patients providing feedback through social media (DiMaggio et al. 2001; Chen & Wellman 2004; Philip et al. 2017). This includes inequalities in access to the Internet (Gilmour 2007); extent of use (van Deursen & van Dijk 2015); understanding of search strategies (Neter & Brainin 2012); quality of Internet connection (Robinson et al. 2015); and the ability to evaluate online health information (Diviani et al. 2015).

Given the growing recognition of the digital exclusion of parts of society (Sparks 2013), it is important to reflect on whether an over-reliance on social media feedback would exclude some patient groups or lead to a focus on issues that were possibly exclusive to those that had privileged access. For example, the potential for a bias toward younger patients providing feedback online has been identified as a risk by some researchers (McCartney 2009; Rozenblum & Bates 2013) and this has been confirmed in a small number of studies (Terlutter et al. 2014; Galizzi et al. 2012a). Whilst there is some evidence that the 'hard-to-reach' groups readily access the internet (Wilkin & Ball-Rokeach 2011; Jensen & Karl 2014) this is countered by growing evidence that the internet actually reinforces inequity in feedback, with access affected by age, sex, education, socioeconomic group, disability and health status (Helsper 2008, Galizzi et al 2012, Emmert and Meier 2013, van Velthoven et al 2018). As more healthcare organisations look to online tools as a way to capture patient

feedback it is important that provision is made for older people and those with lower levels of IT literacy.

4.4.5 Representativeness and Bias

Many healthcare professionals criticise the representativeness of patients providing feedback through social media, arguing that there is inherent bias and that they do not represent the wider patient population (Schlesinger et al. 2015; Verhoef et al. 2014; Lagu et al. 2016). Despite the increasing use of social networking tools by older adults (Hasan & Linger 2016; Hunsaker & Hargittai 2018), Facebook and Twitter users are still largely comprised of adults aged 18 – 34 (Pew Research Center 2019). However the main users of healthcare services are the elderly population. In 2017/18, around one person in three of the Scottish population aged over 75 was admitted at least once to hospital. By way of contrast, around one in twelve people aged 25-44 were admitted (Information Services Division 2018). It is important to note that questions of representativeness and risk of bias are also an issue for traditional paper based methods of capturing feedback. Surveys and questionnaires can be as fallible as online methods in terms of excluding certain groups (Kalucy et al. 2009).

A further reason that some clinicians question the legitimacy of social media feedback relates to the relatively small number of patients choosing to provide feedback through this medium (Patel et al. 2015). In NHS Scotland there were 3200 patient stories posted on the Care Opinion website in 2017/18, but there were 1,201,785 admissions into hospital (Information Services Division 2018). The low number of stories may be partly due to a lack of public awareness of online patient feedback websites as a channel to leave experiential feedback (Galizzi et al. 2012b; Patel et al. 2015; Powell et al. 2015). The small number of stories has the potential for healthcare organisations to contest the results in the event of poor findings, arguing that they are a small unrepresentative minority (Russell 2013). Alternatively the knowledge that external observers are watching the progress of the patient story and its organisational response could in some cases add an impetus and motivation to make improvements. Further research is needed to examine the reasons why

only a small number of patients are using patient feedback sites so that barriers may be identified and addressed.

4.5 Measuring the Impact and Effectiveness of Social Media

In the previous sections I have considered some of the challenges to using social media patient feedback to inform improvement. I will now examine how healthcare organisations measure the impact and effect of online patient feedback. As discussed earlier in this chapter, healthcare organisations are increasingly turning to social media to engage and communicate with their patients. However as social media are substantially different from the traditional communication media (Hoffman & Novak 2012) they require a different approach to measurement, analysis, and management.

A review of the research shows that there is no clear view or consensus on how to measure the impact and effectiveness of social media as a means for engagement and communication (McCann & Barlow 2015). Often organisational measures are focused on the activity i.e. the amount of times a particular tweet or Facebook post has been accessed, "liked" or shared by others users (Peters et al. 2013). However this narrow focus ignores the more qualitative elements of social media, like community, conversations and engagement (Stockdale et al. 2012). Agostino & Sidorova (2016) argue that social media measurement must blend quantitative metrics with qualitative elements such as sentiment analysis and quality of engagement. Measuring these qualitative aspects helps tell the story about what is happening behind the numbers (Blanchard 2011).

Within healthcare there is limited research evidence regarding measures of impact and effectiveness of social media for communicating with patients (Martinez-Millana et al. 2017). A systematic review of the uses, benefits, and limitations of social media for health communication was undertaken by Moorhead et al. (2013) and the authors identified several gaps in the literature regarding social media usage for health communication, including measuring the impact and relative effectiveness of different types of social media.

A particular challenge to measuring impact and effectiveness is the highly dynamic and rapidly evolving social media environment where new platforms emerge and current platforms constantly evolve to take advantage of new technologies that enhance the ability

for users to engage in conversations. The relative newness of social media concepts and approaches, and also the unpredictability of engaging with patients, makes it difficult for healthcare organisations to evaluate what really works, what should be expected as a result, and what is a good result. Further empirical research is essential for healthcare organisations to develop meaningful measures of the impact of social media that go beyond reach and consider outcomes, for example observable changes to practice in response to patient feedback that lead to improvements in the patient experience.

In the following results section of this chapter I will explore the research question and sub-questions that were addressed in a series of interviews with senior healthcare managers from three healthcare organisations (see Methods Chapter for full details of the methods)

Research Question

What are senior healthcare managers' perspectives of using social media patient feedback to improve care?

Sub-Questions:

(i) What do senior healthcare managers perceive as the legitimacy of social media as a source of patient views about their experience of healthcare services

(ii) What do senior healthcare managers see as the benefits and challenges to using social media feedback to improve healthcare services?

4.6 Results

Two overarching themes relating to the use of social media for patient feedback were identified from the participant interviews: (i) barriers to the use of social media within healthcare organisations, including concerns about anonymity of feedback, age and IT skills of patients, organisational and personal reputational risk (ii) mixed views, both positive and negative, regarding the use of social media for capturing patient feedback. These were considered to be frequent themes within the dataset and highly salient for the majority of the participants. The theme titles do not represent exact participant quotes; they have been assigned by the author so as to best describe the themes that were identified (Boyatzis

1998). The results from these two themes are reported below. Illustrative quotes are anonymised to protect participant and organisation identities and are extracted verbatim from original transcripts.

It should be noted that themes are presented as separate categories for the purposes of reporting, but that themes were found to inter-relate. The methods of data collection and analyses are described in detail in the Methods Chapter.

4.6.1 Theme 1: Barriers to the use of social media patient feedback for improvement

Anonymity

In this section I will consider the way in which anonymity is constructed as a barrier to giving patient feedback validity. Many of those interviewed spoke of their apprehension around the anonymous nature of patient feedback on social media platforms like Twitter and Facebook, and the impact it can have on staff.

"If they are just posting a random comment anonymously that you've no way to get back and investigate then that's a bit unfair" (P11)

"*I have concerns about the validity and anonymity of social media patient feedback. If it's anonymous then it's easy to post a defaming comment about an individual*" (P2)

One of the participants interviewed felt that worries about anonymity are common amongst staff in their organisation, where there are genuine concerns about patients using social media anonymously to provide feedback, particularly when identifying individual members of staff.

"Many staff are afraid that if we open this up we're going to get people putting libellous stuff on social media. I think there is a genuine fear that people can be anonymous and hide behind that anonymity" (P16)

These remarks highlight the concern from senior healthcare managers regarding negative or critical patient feedback that might identify or adversely affect individual members of staff.

The following comments further highlight the challenge for staff in relating anonymous social media feedback to specific incidents, making it difficult for healthcare providers to learn from the comments.

"We had a posting once and it sounded like an elderly man that posted it. Part of my response was I'd love to speak to you if you could give me a call – it was a girl aged 22!" (P11)

"We don't know whether it has come from a patient, family or friend. This makes it difficult to respond to. We do try but I feel you have to keep the response woolly rather than more specific because you actually don't know if that's the person" (P5)

The 2 comments above suggest that it is important to staff to know who, or at least the category of person (patient, carer, family), that has provided the online feedback so that they can tailor and personalise their response to this feedback accordingly, rather than providing a generic and possibly inappropriate response. One interpretation might be that healthcare professionals are more comfortable and familiar with face-to-face interactions with patients, where they know the history and background, and find it difficult when faced with anonymous comments where the author is unknown and there are limited facts.

The paradox here is that whilst staff are generally negative about the idea of online patient feedback being anonymous, patients may not provide detailed feedback on their healthcare experience, or any feedback at all, if their anonymity isn't assured. Some interviewees commented on how easy it is for patients to post a defaming or disparaging comment about a member of staff, which can have a negative effect on health professionals. The comments in this section point to perceptions of vulnerability from the health professionals, suggesting perhaps that they see a power imbalance where patients can identify health professionals in their feedback but clinicians do not have a similar mechanism to present their own views. However, whilst the anonymous nature of social media can clearly pose problems for staff it may have specific appeal to those patients with long-term illnesses who do not want to jeopardise the relationship with their healthcare professional.

A common view amongst interviewees was the importance of assessing the source of social media feedback before responding. One participant explained that when receiving patient feedback through social media "*I would always want to know about the individual and what part of the organisation they'd come into contact with before responding to feedback, you need some sense of who the person is before you jump in on it*" (P12)

This view was echoed by another participant in the same board who thought it was important to acknowledge social media feedback, but necessary to check the facts before rushing to respond:

"*I think that it is right to be fairly cautious. I think it is a bit about how do you accept that any feedback is important and take that in and acknowledge that it is important but reserve judgement about factual sort of assertions that are made in it until you've managed to work that out, but accept that their perception is correct*" (P8)

The comments in this section demonstrate some concern from interviewees about the validity of anonymous social media feedback. These concerns are particularly relevant to unsolicited feedback that is posted on social media sites like Facebook and Twitter, where there can be uncertainty about the provenance of the posts. Healthcare organisations and professionals cannot always be sure that the feedback originates from actual patients or that patients are attributing their experiences to the correct healthcare organisation. Central to these concerns are worries about the potential adverse impact on staff and the inability to contact the individual providing feedback.

In the following comments the interviewees discuss the use of the Care Opinion website to gather patient stories about their healthcare experience.

"Patient Opinion is great a way of gathering patient feedback or information that is tailored for a specific purpose. The stories are verified by the Patient Opinion team. Whereas on Facebook and Twitter people feel that they can get away with saying absolutely anything" (P9)

"Patient Opinion is set up to be a forum for feedback and it is much more designed for that. Whereas what we pick up on the other social media channels is by happenchance" (P13)

"One of the positives about a recognised online feedback tool like Patient Opinion is that all stories are reviewed and validated by a member of Patient Opinion staff prior to being made public" (P13)

Interestingly in these three comments above the staff appear to be more accepting of anonymous feedback when it is received through dedicated websites like Patient Opinion rather than postings on 'generic' social media platforms such as Twitter and Facebook. Patient stories posted on Care Opinion require the patient to provide some personal information (including email address) and details of the healthcare service involved. The checking and validation provided by Care Opinion is clearly welcomed by these interviewees and they see it as important in protecting themselves and their organisation from harmful and damaging feedback. It seems that staff feel more confident about the validity and usefulness of feedback through Care Opinion because every patient story goes through a moderation process to check its authenticity and remove information that may identify individuals or allegations about the character of staff (Care Opinion 2018b).

Age & Information Technology Skills

In this section, interviewees discuss age and IT skills as potential barriers to patients providing feedback about their care experience through social media.

Across the staff interviews there were mixed views about the potential impact of age and IT skills on patients using social media to provide feedback on their healthcare experience.

One participant interviewed explained that she worked in a care for the elderly ward and the majority of patients are over the age of 60. She explained that many were reticent to leave feedback online - "*I dinnae bother with that hen*" and "*instead of using Patient Opinion they'd rather write a letter*" (P4)

Another Senior Staff Nurse made the rather sweeping statement – "*The elderly population do not have anything to do with social media*" (P5)

Two of the interviewees also highlighted what they saw as a lack of knowledge or skills in the use of technology and social media as a potential barrier to their use by elderly patients to provide feedback on their care experience.

"Many of our older patients have no interest in social media. They are frightened of computers and find it awkward to use this technology" (P3)

"Our elderly patients prefer to talk. Some of them are on Facebook but many have never used social media and probably wouldn't know where to start" (P15)

Conversely there were some staff who spoke positively about their experience of social media use by elderly patients

"I know a lot of feedback on Care Opinion comes from our older patients. They take the time to tell us about their experience and what could be better" (P12)

"It's easy to assume that the elderly are clueless about social media but that's not my experience. I know many who use it to stay connected with family and we should do more to encourage them to use it to feedback on their care experience" (P13)

One participant described what she perceived as healthcare professionals' pre-conceived view that older patients do not want to use these technologies to leave feedback on their care experience.

"*A bit like we have a paternalistic view to people's healthcare, we somehow have got ourselves into that same way of thinking that the public can't use this technology. We are just so behind the times*". The same participant described her experience of a recent public consultation event where "*three quarters of the people were over 75 and they were the ones pushing for more use of technology and texting*" (P9).

Overall the comments in this section illustrate a range of views and experiences from staff as to whether age and IT skills are a barrier to patients providing feedback through social media. There is an assumption from some that the public uniformly demands the ability to provide feedback online; these comments show that this is not necessarily the case. Some staff reported examples of elderly patients who are happy to use these new technologies to provide feedback, whereas other participants cited first hand examples of elderly patients who were either not able or not willing to engage through these online tools. It signals that healthcare organisations should to be wary of assuming that all elderly people will not want to use social media to provide feedback. The mix of comments from research participants in this study suggests that healthcare organisations need to provide choice when it comes to

routes to provide feedback. Given the shift in demographics, it would be helpful to examine the barriers that elderly people may encounter when using social networks. Identifying these difficulties and exploring the challenges experienced by the elderly patients, such as access, understanding and motivation, will help healthcare organisations facilitate the use of such online feedback tools.

Organisational and Personal Reputational Risk

In a similar vein to the concerns around anonymity and the impact that this can have on individual members of staff, some of the interviewees suggested that a possible barrier to the validity and acceptance of social media feedback by healthcare professionals was a fear of misuse by patients and the resulting reputational risk to the healthcare organisation and professionals involved.

"*There is a need to protect the organisation's reputation"* (P10)

"If something negative is posted online that is maybe not the best about an organisation, how do you then answer to that? How do you reply? It is very difficult. It really has reputational risk to the organisation. So I think that possibly would be a barrier because it is difficult to repair a reputation" (P3)

One participant spoke of his concern about the impact that negative patient comments or feedback on social media might have on the NHS board's reputation.

"Social media has transformed the way we communicate and engage with the public but it has also increased the likelihood of reputational damage. We aren't fearful of a bad reputation so much, but we certainly want to keep our reputation" (P8)

Organisational reputation and perceived responsiveness can also be adversely effected by the quality of reply provided by staff to patient feedback on social media.

"Some of our responses to Patient Opinion can be quite kind of bland or factual. It is sometimes about thinking about how would you want to read the body and the content of what they have said and read into that how you think you should be responding. I think we need to show empathy and understanding, explain what will be done with the feedback and, if necessary, how improvements will be made" (P15)

"*Read the body and the content of what they have said and read into that how do you think you should be responding in their same genre. If they are being a bit tongue in cheek or they are being very emotional then return that to them*" (P11)

"Clearly there is a risk to the organisation, it is a less formal response but it does need to be professional. Professional people do need to be mindful that it isn't a text, it isn't Twitter you know. It needs to reasonably well written. It needs to be plain English so it is cognitive of what is being said and more importantly we all need to be observing organisational values and actually convey the corporate message. It could be quite incendiary, quite political, so there is a risk to be mitigated" (P12)

These comments suggest that rather than putting out a generic response for fear of repercussion, a timely, personalised and empathetic response to negative online patient feedback may help lessen any adverse reputational impact on the healthcare organisation.

As well as the reputational risk to the organisation, a number of the staff interviewed also spoke of the risk to their personal and professional reputation that comes from inaccurate, malicious or defamatory comments from patients on social media.

"I think there is a lot of blame culture now, so patients have got to be really careful what they put on because there are some horrible people out there. I think if somebody was going to make it personal that might make it quite difficult for the individual to deal with, having that information in front of everybody" (P11).

This interviewee went on to comment that the professional identity and confidence of staff can be sometimes shaken by these experiences.

The online reputation of staff was also highlighted in comments from the Head of Communications in one board

"We welcome and value feedback from patients but we must protect our staff from inaccurate or misleading comments" (P7)

Social media content cannot be controlled in advance and the content cannot be managed in the same way as conventional media. Healthcare professionals have always been subject

to reputational risks from damaging comments or gossip. The difference today is the enormous speed and reach with which these can now be spread through social media. The results from these interviews suggest that organisational reputation is important to staff and there is genuine concern that negative social media feedback may adversely affect the standing of the organisation. Likewise participants also expressed concerns about what they perceive as inappropriate or defamatory social media feedback that names individual healthcare professionals and the impact this can have on the personal reputation and morale of those involved.

4.6.2 Theme 2: divergent views from staff regarding the use of social media patient feedback for improvement

Two divergent discourses emerged from the interviews with regard to the use of social media patient feedback for improvement. Many of the staff interviewed spoke positively about the validity and future opportunities for social media as a method for capturing patient feedback

"*Social media is the future for patient feedback and we need to support, embrace and manage it*" (P13)

"*I think we should use every available avenue to receive patient feedback and that includes social media. It is that patient feedback that will help us set the direction for the improvement journey that we need to be on*" (P16)

"*It is early days but it will come. The days of writing on a card and putting it in the postbox, that will be gone. It's not a bad thing but as things progress it is becoming more electronic and it's going down that route. I think definitely for the future that's what it will be, so I think to prepare for that you're going to have to start it now to get there. Otherwise we'll be left behind*" (P3)

There is a sense from these comments that patient feedback through social media is only going to increase in the future and that healthcare organisations need to prepare for and manage it appropriately.

Recognising the changing communication habits in an online world, one participant suggested that social media will be an increasingly important tool for patients to provide feedback on their healthcare experience in the future. She suggests that this is as a result of the younger generation growing up with these technologies and they are therefore more comfortable with sharing their personal information online.

"*I think it is going to become a significant pillar. I do, absolutely. I think in 10 years' time but definitely in 20 years' time when the teenagers now… it is the way they communicate, it's the way the social media generation conduct their lives. Actually a significant number of them don't even pick the phone up, they text each other or they use WhatsApp. Stuff I haven't got a clue about because that's the way they manage their lives. So why would they not give feedback that way. They seem to be less bothered by the fact that that is then in the public. They seem to be quite happy for that to be open to the world. I think that their change in behaviour will drive ours. I think that's an element of a social movement. That's the inevitability of that*" (P13)

This view was echoed by another participant who thought that social media could allow healthcare organisations to get feedback from their younger patients.

"Social media offers us new opportunities to engage with and gather feedback from young people. It's important we hear about the care they've experienced and how things can be improved"(P5)

One research participant also spoke about the younger generation who have grown up with highly interactive digital communication tools, suggesting that healthcare organisations must to adapt to this and understand how they can use this online medium as a source of feedback

"*There is something particularly about a generational thing. So there is something particularly about embracing that in the generation that are coming through, who do that day in day out and it is their way of communicating. If we don't do that then we are going to lose the opportunity for feedback or having as rich a feedback. If that's the medium that people are using then that is the medium that we have to step into*" (P6)

Many of the participants in this study were positive about the use of Care Opinion to capture and share feedback from patients on their experience of health and care services

"Capturing feedback has been difficult unless it goes through the more formal complaints, concerns routes, but for positive feedback in particular we promote the use of Patient Opinion" (P15)

This comment would suggest that healthcare organisations actively encourage and advocate for Care Opinion as the online medium for patients to feedback on positive aspects of their care experience, whereas complaints and concerns are still mainly gathered through traditional complaints mechanisms.

"I think it is great, it is a fantastic medium to speak to your patients and relatives, and to do it with a human factor that is there as well" (P11)

It is interesting to note from the above comment that even in this online space healthcare professionals are valuing ways of signalling relationships, connections and the attributes more commonly associated with face-to-face communication. This would suggest that one of the key reasons that Care Opinion is well liked by health professionals is that it does enable a response that can be done with humanity.

However not all of the staff interviewed were entirely positive about the use of social media patient feedback. Whilst recognising that the nature of communication has changed, along with its increase in speed and volume, some of the staff expressed concerns that there could be a corresponding decline in face-to-face talking with patients.

"*My fear would be over time is that we'll lose the art of the conversation and it turns in to patients just text staff when they could speak to them*" (P8)

"*It will get bigger and I think the days of questionnaires will finish so that it is constantly real time assessment and encouragement and comment. As long as we don't forget how to talk, patients are literally two minutes in the door and they are saying, "How do I get the Wi-Fi nurse?*" (P5)

These comments highlight concerns from some staff that social media might replace the personal touch and connection that comes from face-to-face conversation. These staff feel a

sense of relatedness when they are interacting face to face that maybe isn't there with social media feedback.

"*I think we are going to see more and more of it. I think for me it should never be the only source but it is an important source and it is a powerful source and if we don't support and embrace and manage it in terms of responding to the needs we could easily have a very small group of areas driving something*" (P13)

This viewpoint was echoed by another participant who also identified the importance of talking and how relying on digital communication could lose the richness of information.

"*I don't know what is going to replace Facebook and Twitter over time, some other fancier thing might come in. It's all about communication. It's easier to speak sometimes than it is to text. I don't know whether the next version will facilitate conversations going on without it just going back to phones! I think there is sometimes something missed because it is just a text format*" (P8)

In these comments the staff interviewed recognise that feedback through social media is on the increase but are urging that healthcare organisations employ a range of feedback options to help cater for people with differing communication preferences. There are clearly worries from some staff that a reliance on digital feedback mechanisms could mean that healthcare professionals no longer take the time to engage with patients face to face, talking about their healthcare experience.

One participant made the point that healthcare organisations need to clearly articulate and demonstrate the benefits of engaging with patients through social media, and that making an "*already flawed paper-based system digital will not automatically lead to improvements in quality of services*" (P9)

"*We need to be careful not to use technology to replicate what is already a bad system because all you're doing is electronicifying a process. So how do you make sure that it is that interaction? Our job as an organisation is to make that process happen and then to some extent we need to step back and let the interaction be happening between the appropriate people. Then you've got the whole issue of how do we make sure if we've set up a social media account that we are not just doing it to tick the box because it is the done thing to do.*

But actually our staff can't access it, they don't have the time or they don't have the technology or they don't have the skills to be able to respond back. Then you are just playing lip service to feedback and saying we are now on trend and keeping up with society but actually we are just ticking the box. It is about how we make sure we keep it authentic and real" (P9)

This following comment illustrates the challenge that healthcare organisations may have in meeting patient expectations regarding feedback on social media.

"*The genie is out of the bottle, so it is about how we use it effectively rather than trying to go back to the old ways. It may become the dominant way. The future might be as more and more tech savvy young people who don't work on paper any more then the feedback process will disappear. We will be much more interactive, people will expect responses in real time – none of this you've got 7 days or 14 days or whatever. You've got to balance that with sometimes these are complex issues and you can't have a quick answer to it*" (P8)

In the world of banking, hospitality and retail a speedy reply to online feedback can make the difference to keeping a customer or losing them to a competitor. However in healthcare there is a need to balance the expectation for a quick response with the requirement to understand what are often complex emotional and physical concerns.

Another concern expressed by many staff was the lack of evaluation or robust measures of the impact of social media efforts to engage with patients. When asked about meaningful measures of their digital and social media communications, the staff in all three healthcare organisations said they had basic measures of reach and frequency but little or nothing in place regarding impact and effectiveness.

One participant commented on the lack of qualitative measures regarding the impact of social media in her board:

"*Em only in a kind of binary sense - how many hits, how many tweets, if they were positive. We still look across all of the media, all the feedback, about whether things are positive and negative from newspaper articles, from hits on our page of where to go for your concerns and stuff. It tends to be just binary rather than anything else at the moment*. *The thing for*

me is we have just not got the evidence to show the impact of social media or to show we have really changed" (P13)

In another board one participant described the measures currently used to monitor the impact of social media patient feedback in his organisation as "*fairly crude*".

"*We have had discussions and we do know that our time is shifting from traditional methods to social media for communicating with patients, we need to start reflecting that and where we spend our time. There are robust methods in place for evaluation of traditional feedback methods, the next stage is how do we do this social media bit better*" (P10)

Similarly one participant spoke of the unsophisticated "*accounting metrics"* used to measure the use of feedback made through the Patient Opinion website.

"*I guess we're at the early stages of that from a Patient Opinion perspective. What I see is lots of activity, lots of responding to posts. We get the reports from Patient Opinion direct and we're beginning to get some other data through which is helpful but I don't know we're using it to best effect yet. I think that is work in progress if I'm completely honest*" (P1)

Often evaluation and impact measures can be quite challenging, especially in the case of applying novel technologies like social media, which are not yet thoroughly understood. These comments from interviewees show that some staff consider those measures of impact, where they exist, are rudimentary at best and limited mostly to raw data such as number of followers or tweets. Consequently it is difficult for healthcare organisations to understand what impact they are making on healthcare services with social media patient feedback. In future healthcare organisations should attend to measuring the real impact and actual effects of this group of information technologies.

4.7 Contributions to Knowledge

Whilst previous research on this topic has focussed on the views of frontline clinical staff, this study provides a new insight and understanding on the attitudes and perspectives of senior healthcare managers to the use of social media patient feedback. This is important to healthcare providers and researchers, as the senior managers are a key group who set policy, agree funding and direct the work of frontline clinical staff.

The findings from this study show that there are clear worries from senior healthcare managers that an over reliance on digital feedback mechanisms could mean that healthcare professionals no longer take the time to engage with patients face to face, talking about their healthcare experience. They fear that online feedback may interfere with the development of a personal clinician-patient relationship and they may not be able to establish rapport or empathy with patients. In an online environment it is clear from the findings in this study that healthcare professionals still strongly value ways of signalling relationships and attributes more commonly associated with traditional face-to-face contact in patient-provider interactions.

Senior healthcare managers believe that anonymous unstructured feedback on social media platforms like Twitter and Facebook does not provide sufficiently detailed information to act on and make improvements to care. The findings from this study however show that senior managers consider dedicated patient feedback websites such as Care Opinion can provide this level of detail, whilst also providing a 'safe space' for healthcare professionals to engage with patients online. In particular they value the benefits of a moderated feedback platform where patient stories are reviewed before appearing online and details are removed which might identify an individual member of staff.

The findings from this research study suggest that healthcare organisations reconfigure what they mean by classification of 'positive' and 'negative' patient feedback regarding the quality of health and care services. By categorising the feedback from patients as 'positive' when it provides clear information that is diagnostic of action, the concerns about subjectivity are removed and the value of the feedback is based on an assessment of whether the feedback provides helpful information regarding the actions that could be taken to support improvement.

4.8 Conclusions

In this chapter I set out to explore senior healthcare managers' perceptions of the legitimacy of social media as a source of patient feedback and what they see as the main benefits and barriers to using social media feedback for improvements to care. Conclusions have been

drawn from a review of the published research literature and an analysis of participant interviews. The process of analysis and interpretation from the interview transcripts through to the final findings was explained, and critically discussed in the Methods Chapter.

Interviews with senior healthcare managers revealed a number of factors that contributed to their views on the legitimacy of patient feedback through social media. These included apprehension around the anonymous nature of social media patient feedback; the impact of age and IT skills; the risk to organisational and professional reputation: and concern about the loss of face-to-face communication with patients.

One of the key themes to emerge from the interviews was the concern about the anonymous nature of feedback provided through social media. What I found was fear of misuse by patients and the resulting reputational risk to the healthcare organisation and professionals involved. Some staff felt that anonymity makes it easier for patients to post defaming or maligning feedback about members of staff. These findings are comparable to the previous research in this area that has highlighted clinicians' concerns about social media acting as a vehicle for disgruntled patients to vent frustration over minor shortcomings and the negative impact on professional reputation (McCartney 2009, Jain 2010). The literature shows that anonymous patient feedback through social media can make healthcare professionals feel more vulnerable, particularly when this feedback is publically available.

With regard to anonymous online feedback, two divergent and sometimes conflicting discourses emerged from the interviews. Staff felt that patients might not be open and honest in their online feedback if they aren't able to provide this anonymously. With some patients fearing negative consequences on their ongoing care. However where feedback was provided anonymously staff were concerned that patients could hide behind this. These staff wanted to know its source and be able to check the facts. This is line with the findings of Speed (2009) who identified this as the anonymity/vulnerability paradox. Perhaps not surprisingly the issue of anonymity seemed to be more of a concern for staff when the online patient feedback was adverse or negative. Interviewees did not raise any concerns about anonymous online patient feedback when it was positive in nature.

Interestingly, I found that the source of online patient feedback was a perceived influence on its acceptance and validity by some staff. Interviewees in this study expressed a far more positive attitude to feedback received through the Care Opinion website compared to patient feedback on Facebook or Twitter. It would appear that a number of factors impacted on this; patient stories are reviewed and moderated by Care Opinion staff before appearing online, details are removed which might identify an individual member of staff, patients posting stories are required to provide their email address to Care Opinion.

A further theme to emerge was worries about the loss of face-to-face communication with patients. Whilst most participants recognised that the use of social media by patients is increasing, there was concern from some staff that digital transactions may replace physical interactions and face-to-face conversations. A number of those interviewed said that they wouldn't want to lose the personal touch and meaningful engagement with their patients by relying solely on feedback through social media.

There was also concern from some staff that age and digital literacy might be a barrier to elderly patients providing feedback through social media. What I found was that some staff expressed the belief that elderly patients would not want (or be able) to use social media to provide feedback on their care, suggesting that they might be frightened of the technology and would instead prefer to talk to staff or write a letter. Other participants remarked that this view was 'paternalistic' and that many elderly patients are happy and confident to use social media for feedback. The risk of inequity and potential for a bias towards younger patients providing feedback online has previously been identified in the research literature (McCartney 2009, Rozenblum and Bates 2012).

The findings from this chapter support the use of social media as a valid source for patient feedback on their experience of healthcare services. However there was a strong message from interviewees that healthcare organisations must provide a range of methods for patients to provide feedback on their care and that social media patient feedback should complement and augment rather than replace existing methods.

5. Discussion and Conclusions

5.1 Introduction

In this final chapter I will discuss the research findings in relation to the relevant literature, reflecting on the objectives of the study and the outcomes of the analysis. I will then discuss the contribution of this study to research; support for implementation of the findings; the implications of the research findings for healthcare policy and practice; and make suggestions for further research. Finally I will briefly outline the limitations of the study and make some personal reflections on my Professional Doctorate journey.

This research study sought to address the following question:

What are senior healthcare managers' perspectives of using social media patient feedback to improve care?

5.2 Discussion

This research study set out to explore senior healthcare managers' attitudes to and acceptance of online patient feedback, and its potential to inform improvements to health and care services. An evaluative critical review and analysis of the relevant research literature is located within the 'Patient Experience and Feedback' and the 'Using Social Media as Patient Feedback' chapters. Adopting a qualitative approach, semi-structured interviews were conducted with 18 senior healthcare managers from three National Health Service Boards in Scotland. A process of Framework Analysis was used to identify the key themes expressed by interview participants. The data analysis process is discussed in detail in the 'Methods Chapter'.

It was evident from the participant interviews that senior healthcare managers' experience of online patient feedback varied, however there were a number of common themes that emerged from the interviews. In this section I have organised and reported the key findings

from this study under 6 headings. General statements are introduced to summarise each of the key findings. While each theme is distinct, they build on each other to give an insight and understanding of senior healthcare managers' perceptions and attitudes on social media patient feedback.

1. Can Patients judge the quality of their own care?

Patient experience is a multi-dimensional concept that incorporates both the clinical/technical aspects of care as well as the interpersonal/humanistic aspects of the clinician–patient relationship (Murrells et al. 2013; Zinckernagel et al. 2017). The clinical/technical aspects of care relate to diagnostic tests, treatment, medication and clinical effectiveness outcomes. Whereas the interpersonal aspects of care refer to the relational factors such as the ability of healthcare professionals to communicate and empathise with the patient, involve them in joint decision-making and provide information to support self-care. Whether patients can judge the quality of these different aspects of care is a foundational issue and one that continues to foster debate in the published research literature (Bopp 1990; Chapple et al. 2002; Coulter 2006; Marcinowicz et al. 2009). Participants in this study expressed a range of views regarding the ability of patients to judge the quality of their own care. Whilst many of the participants felt that patients are competent to provide feedback on the interpersonal and humanistic elements of care, there were some participants who argued that patients lack the necessary knowledge to make any evaluation of the technical skills of the health professional.

Who defines quality and how is it measured are key questions for those engaged in improving healthcare and services. Traditionally, quality of care has largely been defined by the healthcare professional and relates to the effectiveness of those measurable aspects of technical and clinical care (Lohr et al. 1988). However this position has changed in recent years with a growing recognition that patients' have a legitimate role in defining and evaluating the quality of care (Doyle et al. 2013) and that quality merges excellent clinical care with communication, compassion and empathy that also address the emotional needs of patients.

Although the numbers are relatively small, the results from this study do show variability in views from medical and non-medical participants regarding a patient's ability to judge their own care. In general the nursing and administrative participants in this study considered that patients are able to judge both the interpersonal and technical aspects of their care. Whereas the medical participants argued that patients were not qualified or competent to evaluate the clinical and technical aspects of the care they receive. These findings are consistent with recent research by the Point of Care Foundation (2019) that show many medical practitioners are sceptical about the validity of patient feedback, certainly with regard to feedback on the clinical aspects, as they do not believe patients are knowledgeable enough to comment on this aspect of their care. This scepticism makes it easier for some medical professionals to disregard or discredit patient feedback that they do not agree with. The attitudes and beliefs of healthcare professionals can act as both facilitators and barriers to implementation and acceptance of new initiatives like using social media feedback. Any doubts or distrust from healthcare professionals that online patient feedback will help improve patient care or the quality of services may mean that its adoption and promotion is hampered. It is unlikely that patient feedback will be effective in informing improvement if it is not perceived to be credible and useful by healthcare professionals.

2. What is the legitimacy of patient feedback?

In line with the published research (McCarthy & Wright 2004; Bate & Robert 2006) there were a range of perspectives from the participants in this study regarding the legitimacy of patient feedback. These broadly fall into 2 contrasting views:

- Patient feedback is valid and legitimate; it reflects what is important to the patient
- Patient feedback isn't as valid as objective clinical measures. It is a highly subjective set of thoughts informed by a wide range of influences, such as previous experience, inner fears, and expectations

Some participants in this study questioned the legitimacy of patient feedback from any source, considering it to be highly subjective. These participants asserted that patient

feedback is often shaped by factors outside the influence of the healthcare organisation, such as prior experience of family members or friends, and that, unlike objective clinical measures, patient feedback is subjective, selective and prone to mood differences. Medicine and the training of medical staff stresses the scientific and rational application of objective clinical evidence. A common message emerging from the medical participants in this study was that, as clinicians, they are judged on giving the right care, and that the right care is based on correct diagnosis and an evidence-based, efficacious treatment plan. Thus patient feedback is often dismissed as being too subjective and divorced from the 'real' clinical work of measuring effectiveness and safety. This suggests that for some healthcare professionals working in an evidence-based system like medicine there is an enduring sense that 'hard' numerical evidence is more reliable than 'soft' patient feedback, which is deemed to be unreliable and doesn't have the evidential standing of dispassionate clinical measures/outcomes.

As highlighted in the previous section in this chapter there was a difference in views between medical and non-medical staff in this study regarding the legitimacy of patient feedback. Comments from many of the nursing and patient experience staff in this study showed that they valued all patient feedback, however they felt that this was not the case with their medical colleagues who they believed were less engaged and sometimes viewed patient feedback as something for nursing staff to deal with. It is evident from the results of this study that medical and non-medical staff view the legitimacy of patient feedback differently and some doctors believe quality of care should be judged on good clinical outcomes rather the interpersonal/relational aspects of care, where they question the legitimacy and evidential standing of this information.

These findings suggest that further work is required with both nursing and medical staff groups to recognise and understand the two distinct but complimentary forms of knowledge gained from measurable clinical processes/outcomes and from patient feedback on their care experience.

3. How should patient feedback be represented, to whom and when?

Patient feedback data are used by healthcare organisations to make judgements, to answer questions, and to monitor and support improvement in healthcare. The same data can be used in different ways, depending on what we want to know or learn. Principally, healthcare organisations use patient feedback for two key functions:

1. Patient Feedback for Assurance

Healthcare organisations use patient feedback, often in the form of surveys, to help monitor and assure that they are providing an acceptable quality of care and services for patients. This summative approach is usually concerned with establishing levels of performance to identify whether a specific target has been reached or not; it is not concerned with incremental change or improvement of individual services.

2. Patient Feedback for Improvement

Healthcare organisations use patient feedback as a formative mechanism to identify opportunities for improvements to care and services for patients. This information, often in the form of patient stories, is used to start discussions about quality differences and motivate change in staff behaviours.

There can sometimes be a tension between using patient feedback to facilitate improvement and its use for accountability and assurance purposes (Boiko et al. 2015). If patient feedback data is used or interpreted incorrectly there is a danger that the wrong conclusions are reached and, at worst, false assurance is provided or inappropriate action taken.

When using patient feedback for assurance and accountability purposes, healthcare organisations must consider the mechanisms used to gather this information for issues related to design, administration, representativeness, sample size and bias (Boiko et al. 2015). Data used for governance and assurance purposes can have a tendency to subvert trust and respect for the expertise of frontline staff, and is often associated with a ‘name and shame’ approach. However an approach that focuses on value rather than validity, on content rather than form, is more likely to be a catalyst for change. Patient feedback used

for improvement provides information internally to individual services and teams as a stimulus for engaging in dialogue to improve practice. This dialogue can be supported through structured small tests of change such as Plan, Do, Study, Act" (PDSA) cycles (Taylor et al. 2014). In this way, patient feedback can be used to help learn about how a test fared and to create change.

A number of participants in this study expressed concern that non-executive board members and senior managers in their organisation are overly focused on attempts to aggregate patient feedback into quantifiable data, thus losing the important narrative. There is a perception here that senior managers are mostly interested in using the patient feedback for assurance purposes, whereas the frontline staff are concerned with the individual patient and how their feedback is diagnostic of areas for improvement. That is, feedback is being summarised and quantified to provide assurance to the board members that the healthcare organisation is providing an acceptable level of care to their patients, rather than using this information to identify actionable areas for improvement to care and services. The results of this research indicate that some senior healthcare managers believe attempts to quantify patient experience are an overly simplistic reduction of what are a complex range of factors and suggests there may be a possible disconnect between frontline staff and senior managers in how patient feedback is presented and used. At NHS Board organisational level there will always be a continued need for robust longitudinal and comparative reporting of patient feedback. Aggregating patient feedback in this way increases the volume and diversity of patient-centred insights into the quality of care (Griffiths & Leaver 2018) and meets the needs of reporting to regulatory bodies such as Care Quality Commission and Healthcare Improvement Scotland. However this process of reducing the complex reality of healthcare interactions to numbers and summary generalisations could be considered mechanistic or reductionist. The evidence from participants in this study is that patient feedback becomes most useful when it sparks conversations between clinicians and patients about what needs to change.

The findings from this study are consistent with research by Sheard et al. (2017) who suggest there needs to be less concentration by senior management on the formal metrics. The authors describe a patient feedback "chasm" between senior management and frontline health professionals whereby managers invest heavily in measuring patient

feedback but have little or no plans for how to facilitate staff to enact subsequent improvement. It is interesting to note at this point a clear recurring theme in the findings from this study is how staff in different roles are concerned about different areas of patient feedback and that there is a range of agendas as to how the feedback should be used. If healthcare organisations are to maximise the use of patient feedback then they must adopt the principle of 'collect once and use many times', where feedback can be analysed and reported in different ways to meet the needs of different audiences.

Further research is needed on how, when and in what circumstances assurance and improvement mechanisms can be used together to build a coherent system for learning from patient feedback. By adopting an improvement approach, performance is still monitored and additional assurance is taken by confirming that an improvement culture is emerging at the frontline. This can validate and confirm improvements to patient care by connecting the patient feedback to the staff and units where the work is being done.

4. Preference for quantified versus qualitative reporting

The findings from this study highlight the diversity of views from senior healthcare managers regarding the reporting of patient feedback. How this feedback gets represented is variable and depends on the role and nature of the feedback. Some participants reported that quantification of patient feedback is necessary and can be helpful in answering questions such as how many, how often, who and where. Examples were provided of aggregating and summarising patient feedback to identify common themes, opinions, experiences, and other defined variables. This quantification of patient feedback means assigning greater value to the views of the many rather than the few.

Qualitative information, often gathered through patient stories, is necessary for healthcare organisations to build an understanding of the underlying reasons, opinions and motivations in patient feedback. Many of the participants in this study felt that qualitative patient stories add rich, detailed, specific and pertinent insight to the scene drawn by quantitative data and can suggest areas where better quantitative data collection is needed. The suggestion here is that the value of qualitative patient feedback lies in their ability to add emotional force to

convince others of the need for improvement. In each of the healthcare organisations senior staff described how they are working with board members to help them understand the depth and complexity of patient feedback, moving away from an assurance focus to building commitment and support for the design of specific quality improvements.

Taken together these findings suggest that there is a need for healthcare organisations to employ both quantitative and qualitative reporting of patient feedback. This is consistent with previous published research, which shows that engagement with patient feedback may be enhanced by including patients' comments alongside numerical data (Reeves & Seccombe 2008; Reeves et al. 2013). Using quantitative and qualitative reporting together would help address the challenge of providing high-level organisational metrics and the granular intelligence that is necessary to inform improvement. At a board level non-executive directors need an overall view of the recurrent trends or common themes arising from patient feedback in order to develop strategies, target resources and benchmark services. Whereas at a team and ward level the staff need the more detailed qualitative patient feedback in order to influence decision making and inform quality improvement initiatives at the frontline.

5. Impact of negative and positive patient feedback on staff

The previous research shows that critical or negative patient feedback can have a demoralising effect on those staff involved (Schrøder et al. 2019). Healthcare professionals receiving critical feedback from patients may experience loss of self-esteem, feelings of anger, frustration and a fear of continued practice (Seys et al. 2013). Participants in this study described having a similar strong emotional response to negative patient feedback, often left feeling defensive and demoralised. It is important to note that these participant experiences were related to feedback provided through the more traditional paper-based routes. Whilst participants did not provide specific examples of where this had yet happened with patient feedback through social media, they did anticipate that this type of negative feedback could have an impact on their personal and/or organisational reputation. The un-moderated nature of platforms like Facebook and Twitter allows patients to say

what they like, and this is concerning for healthcare professionals. It is interesting to note that the research participants in this study were often speculating about or anticipating concerns that had not yet been realised regarding social media patient feedback, rather than describing specific examples of where this had already occurred. There was no real evidence from social media that staff and their practice have been called out on social media. At this stage it appears that the fear may be bigger than the reality for healthcare professionals.

Healthcare professionals have always been subject to negative and challenging patient feedback through the traditional paper-based methods like questionnaires, surveys and letters (Brookes & Baker 2017). However the participants in this study were specifically concerned that this could increase in the case of patient feedback using social media because of its openness, transparency and wide reach. Some of the participants suggested that this could be an important barrier to the validity and acceptance of social media feedback by healthcare professionals. Whilst there is no clear evidence from the interviews as to what these views on the potential effect of negative feedback are anchored to, it is likely that the concerns could be coming from personal experience or media reports of social media abuse and harassment in relation to other areas outside of health. It is possible that healthcare professionals are transferring their fear of social media misuse from their personal world or extrapolating from other combative exchanges they have had offline to their professional world.

An equally legitimate role for patient feedback is in affirming good staff and high-quality care. Consistent with the published research (Baines et al. 2018) the results from this study demonstrate the encouraging and affirmative impact that positive patient feedback has on healthcare professionals. Participants reported that positive feedback, through both traditional and online methods, has a constructive impact on the emotions and experience of care providers themselves, making them feel appreciated and valued. Results from previous studies have demonstrated a strong relationship between staff morale and patient experience (Sergeant & Laws-Chapman 2012), illustrating how the emotional wellbeing of

healthcare professionals affects their ability to undertake daily activities and their ability to care for patients. The visibility of positive patient feedback on social media is an important way to demonstrate to patients, peers, and management that healthcare professionals are doing a good job. Recognising individuals/teams who have performed well may also inspire other staff to follow their example. Healthcare organisations could consider whether there might be opportunities to increase visibility and share the positive feedback from social media, perhaps through display screens in reception and waiting areas.

Previous research by Edwards et al. (2011) reported that positive feedback rarely led to actionable change as it was simply considered a positive affirmation of conduct, behaviours and practice. However actionable change is possible from both negative and positive patient feedback. Aside from the encouraging and affirming effects on staff morale discussed above, participants in this study described how positive feedback is used to identify what is working well, share good practice or areas of innovation, and inform staff training.

Interestingly, whilst some participants in this study questioned the legitimacy of patient feedback from any source due to its subjectivity, none of the participants questioned whether the positive feedback received by healthcare professionals was influenced by previous experience, expectations or emotions. This is a very selective questioning of subjectivity, which may show certain biases in how the patient feedback is received by senior managers. An implication of this possibility is that some senior managers are accepting what they want from patient feedback whilst ignoring or refuting negative viewpoints that are inconsistent with their own perceptions.

It was evident from participant interviews that healthcare organisations actively promote Care Opinion as a route for patients to provide positive feedback. However patients with concerns and complaints are still encouraged by staff to use the formal organisational complaints process. This suggests that in some areas there might be a need for better promotion of Care Opinion as a legitimate route for any critical comments or concerns, as

well as the more positive feedback. This could lead to an earlier satisfactory solution and avoid escalation of lower level concerns before they become an official complaint. However it is important to recognise that there will always be a need for an official complaints process for those more serious issues relating to patient safety, care and treatment.

6. The legitimacy of online patient feedback

In this study the participant comments about social media patient feedback tended to be linked to particular platforms or dedicated websites, rather than speaking more generically. In line with the recent research into online patient feedback by Atherton et al. (2019) the findings in this study show that senior healthcare managers believe that unstructured feedback on social media platforms like Twitter and Facebook does not provide sufficiently detailed information to act on and make improvements to care. Participants in this study reported similar concerns and suggested that character restrictions in Twitter seriously limit the level of detail and context in patient feedback. However participants did report that information from Twitter and Facebook should be used by healthcare organisations to identify common general themes in relation to quality of care and services. Dudhwala et al. (2017) use the term SSS (sanctioned, solicited, sought) to distinguish between online feedback that healthcare organisations support, and that which exists independently. In NHS Scotland the Scottish Government financially supports and promotes the use of Care Opinion as the single recognised website for patients and carers to provide online feedback on their experience of care and services (Scottish Government 2019). In comparison to the generic social media platforms where participants felt that patient feedback is often picked up by happenchance, senior healthcare managers were much more positive about Care Opinion as a method for capturing patient feedback and using this information to inform improvements to care and services. The participants in this study felt that Care Opinion provided healthcare professionals the opportunity to engage with patients online but still retain empathy and compassion in their interaction. It is interesting to note that even in this online space healthcare professionals are valuing ways of signalling relationships, connections and the attributes more commonly associated with face-to-face communication. This would suggest that one of the key reasons that Care Opinion is well

liked by health professionals is that it does enable a response that can be done with humanity.

A further interesting finding from this study was participants' views regarding the quality of response provided by healthcare professionals to patient stories posted on Care Opinion. Some healthcare professionals are providing standardised, formulaic replies to the patient stories on Care Opinion rather than tailored personalised responses. This arguably reflects a degree of managerial control and a desire to take these discussions offline rather than continue the communication in a public forum. Whilst standardised replies to patient stories on Care Opinion allow for a consistent organisational message, this type of response risks alienating or antagonising patients and may infer a lack of concern for the patients' perspective. Most participants in this study argued strongly that any response to feedback on Care Opinion has to be both personalised and authentic. This is in line with recent research by Baines et al. (2018), which recommended that healthcare organisations should align their response processes for online feedback with patient aspirations and desires. Participants in this study differentiated a response to Care Opinion feedback from that required for the NHS complaints process, which necessitates a formal structured response. What is clear from this is that healthcare professionals perceive a good response to patient feedback as one that is personal, and even in this online space healthcare professionals are valuing the personal approach.

A further reason that participants in this study supported the use of Care Opinion was the reassurance that prior to publication on the website the feedback from patients goes through a moderation process to check its authenticity and delete person identifiable information. Patient feedback on Care Opinion provides a 'safety net' for healthcare professionals where, unlike the generic social media platforms, they can be sure that the patient feedback has been reviewed and any allegations about the character or motivations of care staff have been removed.

Very few examples were provided by participants in this study of patient stories on the Care Opinion website being used to inform improvements to care and services. Across Scotland data on the Care Opinion website shows that 3200 patient stories were published during 2017/18, with 66 (2%) resulting in change or change being planned (Care Opinion 2018). The majority of patient feedback on Care Opinion is of a positive nature (67% of stories are positive, sharing thanks and appreciation). This is in line with research by Atherton et al. (2019) who found that found that one of the main motivations for patients to provide online feedback was to praise a service. The very small number of patient stories resulting in change does however question whether there are opportunities for change that are not being taken and/or that healthcare organisations need to expand their concept of what is actionable. For example actions resulting from positive feedback could include communicating positive patient feedback to the staff or rolling out low-cost 'good practice' to other areas. This study did not look at why patients choose (or not) to post feedback using Care Opinion but one reason could be that patients would prefer to report the more serious concerns through the existing offline routes, for example the formal complaints process, rather than in a public online forum.

5.3 Contribution to Research

This research study provides the first detailed insight into the views and attitudes of senior healthcare managers regarding the use of social media patient feedback for quality improvement. The evidence from this study provides an understanding of what patient feedback means to senior managers and how these views and attitudes drive behaviours with regard to validity and acceptance of online patient feedback. Specifically the contribution that this study makes to the body of knowledge is detailed below:

(i) This study provides an insight into the main barriers to the validity and acceptance of social media patient feedback by senior healthcare managers. These are (i) the anonymous nature of social media; (ii) the impact of patients' age and IT skills; (iii) the risk to organisational and professional reputation; and (iv) concern about the loss of face-to-face communication with patients.

(ii) There is concern from senior healthcare managers that the use of social media will increase the amount negative patient feedback. However this concern appears to be based on speculation and is anticipating concerns that have not yet been realised. At this stage the fear of an increase in negative online patient feedback is bigger than the reality.

(iii) Whilst negative patient feedback was often criticised by senior managers as being too subjective, participants did not question whether positive patient feedback is also influenced by previous experience, expectations or emotions. This very selective questioning of subjectivity may show certain biases in how the online patient feedback is received by senior managers, thus accepting what they want from feedback whilst ignoring or refuting negative viewpoints that are inconsistent with their own perceptions.

(iv) The conventional approach to analysis and classification of patient feedback is to group this information into 'positive' and 'negative' comments regarding the quality of health and care services. However the findings from this research study suggest that healthcare organisations reconfigure what they mean by 'positive' and 'negative' in this context. By categorising the feedback from patients as 'positive' when it provides clear information that is diagnostic of action, the concerns about subjectivity are removed and the value of the feedback is based on an assessment of whether the feedback provides helpful information regarding the actions that could be taken to support improvement.

(v) The findings from this study show that senior healthcare managers do not believe that unstructured patient feedback through Facebook or Twitter contains sufficient level of detail for healthcare organisations to identify the concern and make improvements to healthcare services.

(vi) Senior managers value ways of signalling relationships and the attributes that are more commonly associated with face-to-face patient communication. Care Opinion provides them with the opportunity to engage with patients online but still retain empathy and compassion in this interaction. Patient feedback on Care Opinion provides a 'safety net' for healthcare professionals where they can be sure that the patient feedback has been reviewed and any allegations about the character or motivations of staff have been removed.

5.4 Implications for healthcare policy and practice

The findings from this research study have a number of implications for the development of healthcare policy regarding patient feedback and experience, as well as for healthcare organisations in trying to maximise the benefit and impact of this information.

1. Healthcare organisations must recognise the learning opportunities from positive feedback received through social media and support staff in dealing with negative feedback

The beneficial impact to healthcare professionals of receiving positive feedback should not be underestimated. Many of the interviewees in this study spoke of the benefits from receiving positive patient feedback; not only in identifying areas of good practice and sharing what is working well, but also to boost morale, motivation and make staff feel valued.

Promoting, celebrating and learning from positive patient feedback can be as valuable as learning from examples of less positive experience. Healthcare organisations should recognise the opportunities that positive patient feedback brings to identifying, sharing and learning about what is working well. Linking patient feedback systems with organisational systems for learning and improvement will maximise the opportunities for supporting change, where necessary, and for disseminating good practice across different units and teams in the organisation.

Evidence from the research literature (McCartney 2009; Jain 2010) and from interviews with study participants highlights the effect of negative or critical feedback from patients, often leading to anger, denial, defensive or dismissive behaviours from staff. It is important to note that these observations were in the main grounded in offline situations and the participants' fear was that the open nature of social media would make negative feedback easier and more visible.

Processing negative patient feedback is not always easy. It can make healthcare professionals feel defensive, angry, and self-conscious, which subsequently impairs their effectiveness and

may cause them to practice more defensively. Critical online patient feedback can also have a negative impact on personal reputation and professional identity (Wilson et al., 2013). The individual desire to do good leads to healthcare professionals holding a high expectation of providing above average care (Sargeant et al 2007). When patient feedback challenges or conflicts with this self-perception it can be difficult for staff to assimilate. It is therefore important for healthcare organisations to understand how negative patient feedback impacts on healthcare professionals and how these effects can be ameliorated. To help manage and mitigate the damaging emotional impact healthcare organisations should encourage staff to view critical feedback not as a negative personal attack on them; rather it is feedback about the system and processes in which they work.

Healthcare organisations need a more systematic approach to supporting staff to deal with negative patient feedback. Both structural and process interventions are needed at individual, team and organisational level. Healthcare organisations that use negative patient feedback as a form of performance evaluation should seek to alter existing cultures enabling patient feedback to become a valued and embedded activity. This means moving away from a name, blame and shame culture to one that is non-punitive, compassionate and collaborative. Healthcare organisations must provide an honest and protected space in which to allow healthcare professionals to openly reflect and, where needed, acknowledge problems without fear or consequence (Ladher and Godlee 2018)

One of the most frequently experienced barriers to behavioural change is working in an environment that is not conducive to lifelong reflective learning (Overeem et al 2009). Reflective and facilitated discussion is helpful in transforming initial reactions to negative patient feedback into behavioural change, quality improvement or education (Sargeant et al 2011). Sharing the learning from any changes resulting from negative online feedback as widely as appropriate will maximise any positive outcomes from these inherently negative events

Interventions at the level of the individual and the team should be focused on understanding and overcoming the emotional impact of negative patient feedback. This could involve providing proactive support, mentorship, coping strategies and resilience training to help ameliorate these emotional reactions to negative feedback and enable staff to focus more effectively on patients' experience. With this support in place, healthcare professionals can hear critical online patient feedback openly and calmly, understand what it is saying, and harness it to improve without damage to their confidence and self-perception.

Healthcare organisations and professional regulatory bodies in the UK publish guidance for their staff and members regarding appropriate use of social media, including privacy, confidentiality and maintaining professional boundaries. The results from this study show that there may be a need for these bodies to supplement this guidance with advice on how to handle critical online patient feedback and helping professionals to be resilient in that regard. This could be done through the use of case studies and stories of real life scenarios showing how these situations have been handled.

2. Board reporting should incorporate in-depth qualitative information from patient stories captured through social media and quantitative data from surveys and questionnaires

The findings from this study demonstrate there is a requirement for both qualitative and quantitative reporting of patient feedback on the care experience and that both contribute important aspects. Quantitative reporting is essential for senior management to identify common themes, develop strategies, target resources and benchmark services. However these metrics will only tell you the 'what', not necessarily the 'why'. There is a risk that the rich patient information from patient stories might be lost when aggregated up and summarised in an attempt to arrive at more tractable issues. Qualitative data is also needed in order to understand what actionable changes can be applied locally to make improvements to care and services. Healthcare organisations and policy makers should consider the potential role of patient feedback, and their place in a system in which formal,

quantitative metrics still dominate. This will help demonstrate to staff that the patient voice is being heard at the most senior level, and that patient feedback, from whatever source, is being used to improve, monitor and assure the quality of care.

3. Healthcare organisations should consider integrating patient feedback from a range of sources in order to understand whether this provides additional insight to those aspects of the care experience that need improvement

Several methods of gathering patient feedback have been described in the literature (Ziebland 2013; Sheard et al. 2019) and each has their pros and cons. No single approach to gathering feedback will be effective for all patients or in all circumstances (LaVela & Gallan 2014). Healthcare organisations need to develop an understanding of the profile of patient feedback that comes from different sources, understand how actionability is assigned for each method and whether this is done in the same way across each of these sources of patient feedback.

The findings from this study show that a multi-modal approach is required for healthcare organisations to obtain meaningful, actionable patient feedback from across the patient population. Healthcare organisations could consider how they look across patient feedback from multiple sources (surveys, websites, social media, audits and complaints) and bring together these islands of information to reveal the links, themes and connections, and avoid patient feedback data silos. Structures and systems will vary from organisation to organisation but to maximise the benefit and connections will require the patient experience, complaints, improvement and communications teams working together to combine and share their information on the patient experience. The main challenge is to consolidate these different streams of patient feedback into a single, meaningful format that can be easily and efficiently interpreted. Careful consideration is required as to how

patient feedback is brought together in order to ensure consistency and accuracy, and the depth of information collected from each source. Combining a mix of data collection methods that elicit patient feedback, including surveys and patient stories, McCance et al. (2012) have developed a complimentary set of patient experience key performance indicators (Table 7) and supporting measurement framework. This approach to measurement privileges the patient voice by using methods that prioritise patient feedback. Testing in a range of practice settings (McCance et al. 2015) has shown that these indicators produce meaningful evidence that has the potential to drive improvements in the quality of the patient experience and provides a framework for governance and assurance.

Table 7: Key Performance Indicators

Consistent delivery of care against identified need
Patient's confidence in the knowledge and skills of staff
Patient's sense of safety
Patient involvement in decisions made about their care
Time spent with the patient
Respect for patient's preference and choice
Support for patients to care for themselves
Knowing what is important to the patient

Healthcare organisations and policy makers should consider a trial of these indicators and measurement framework to identify whether this evidence-based mechanism provides additional insight to illustrate the patient experience. The data sources used by McCance at al focused on patient surveys, interviews and practice observation. These could be further enhanced by including patient feedback from online sources such as Care Opinion and NHS Choices. This would provide additional and complimentary evidence of what is important to patients and what would improve their experience. Integrating information from these offline and online sources may also allow healthcare organisations to identify their high performing teams and units and increase their understanding of why things go right.

5.5 Supporting the implementation of findings from this study

Using my position in Healthcare Improvement Scotland (HIS) there are a number of opportunities to influence and support the implementation of the findings from this study:

(i) NHS Board Member Masterclasses

I will work with board members (executive and non-executive directors) to help them understand the depth and complexity of patient feedback, moving away from an assurance focus to building commitment and support for the design of specific quality improvements.

(ii) The Person-centred Health and Care Programme

Within HIS this programme supports improvements in person-centred care and practice across healthcare organisations in Scotland. This programme is very well placed to work with nursing and medical staff groups to help them recognise and understand the two distinct but complimentary forms of knowledge that can be gained from measurable clinical processes/outcomes and from patient feedback on their care experience.

(iii) Quality Assurance and Reviews

As Senior Reviewer within HIS I will use our inspection and review activities to explore how healthcare organisations in Scotland are using online patient feedback to monitor and improve quality of care; assess whether staff feel supported to deal with negative or critical feedback, and understand how patient feedback is reported to and used by board members.

(iv) Scottish Health Council (SHC)

As a unit within HIS, the SHC supports NHS Boards to gather and respond to feedback from people and local communities, so that services are informed by, and responsive to, their needs and preferences. I will work with SHC colleagues to learn from the findings of this study and help healthcare organisations to improve communication between the people delivering services and those who use them.

(v) National Sharing Intelligence for Health & Care Group (SIHCG)

This group brings together the improvement and assurance bodies from across Scotland to share, consider, and respond to quantitative and qualitative intelligence about care systems across Scotland. I will work with this group to understand how we as regulators learn from online patient feedback sources like Care Opinion and maximise the value and benefit of this information.

5.6 Further research opportunities

The findings from this study give rise to opportunities for future research that would be valuable for policy makers, healthcare organisations and health professionals.

1. There is currently little published research regarding the use of social media patient feedback to inform improvements to care and services, and what there is focuses more on claims for the potential of this new medium rather than providing evidence of where it has been used effectively to inform changes. More case studies and practical outcome based research of where and how this type of feedback has actually been used to bring about improvements to care and services would be beneficial for healthcare organisations.

2. Further research is required to recognise and understand the different roles of the various routes for patients to feedback on their concerns. It would be helpful for healthcare organisations and policy makers to understand why people choose to use different mechanisms and what each mechanism achieves. In particular it would be helpful to understand why only a proportionately small number of patients are choosing to provide feedback on their healthcare experience through Care Opinion. This will help healthcare organisations understand what some of the patient barriers are to providing feedback online and how these could be addressed.

3. There is a need for healthcare systems to understand the impact of all programmes and systems they put in place to deliver better care. If healthcare organisations and government are investing limited resources in collecting and analysing social media patient feedback, how do they know that this is money well spent? Research is required into the development of meaningful measures of the impact of social media feedback that go beyond reach and consider the usefulness, effectiveness and value of online patient feedback to the organisation.

4. Harvesting user experience information from social media is widely used in the service and hospitality industries. Using analytic tools like sentiment analysis and opinion mining, major customer oriented organisations gather social media feedback and turn this unstructured data into actionable intelligence. These organisations dedicate significant resources to protecting their online reputation. Further research would be helpful to understand what knowledge and experience exists and is transferable from other industries in the capture and learning from social media feedback to inform improvements to services.

5.7 Limitations

The limitations in relation to the use of qualitative methods and semi-structured questionnaires are discussed in the Methods Chapter. Further potential limitations for this study are outlined below.

A common criticism of qualitative research is the degree to which the findings can be generalised. The intention in this small study was to build an in-depth understanding of what social media patient feedback means to senior healthcare managers in the three healthcare organisations involved in this study. However the possibility of inferential generalisability exists, whereby the findings from this study may be pertinent to other settings or contexts (Ritchie & Lewis 2003). Whilst there will always be factors that make a setting or population unique, the robust methodological approach and detailed accounts of participant experiences in this study provide a comprehensive picture of the subject and allow others to make an informed decision on the transferability of the findings to their own context and situation.

A potential limitation relates to how the research participants were selected for the study. I was dependent upon referral of potential interviewees by senior colleagues in each of the three healthcare organisations. These colleagues may have been consciously or unconsciously selective about who they thought would be suitable and whom they were happy for me to interview. However, I had no indication that they were acting as a gatekeeper in this way and the interviewees in this study spoke freely to reveal a wide range of differing opinions and experiences.

All data collection and analysis methods have inherent limitations. I did not ask the participants in this study to comment on their interview transcripts or on my interpretation of the findings as I felt respondent validation was unnecessary for this study. Furthermore I undertook the coding and data analysis myself for this research study and therefore this

reflects only one view on interpretation. To address this potential limitation the emerging themes were checked and discussed with my supervisor on a regular basis and a number of quotations from the interview respondents have been included to attempt to mitigate this limitation.

One important distinction between qualitative and quantitative research is the role the researcher plays in the process. My role as Senior Inspector with Healthcare Improvement Scotland (HIS) may have had an influence on how research participants chose to engage in this study and answer the interview questions. As the national quality assurance body for the health service in Scotland, HIS inspects the quality and safety of all healthcare organisations. I find that healthcare staff will often tell the inspector what they think he or she wants to hear. As such there was a risk that interview participants in this study would not interact freely with me having known me in my HIS Senior Inspector role. In order to address this concern and minimise any participant bias, I explained to interviewees that this research was not part of any HIS inspection or quality assurance activity and that all interviews would be fully anonymised. My role in HIS did afford me some advantages, as it enabled me to gain introductions to the healthcare organisations and to particular senior individuals with whom I had previously formed relationships.

5.8 Personal Reflections

The role, interests and values of the researcher can have a strong influence on their research relationships and findings, whether this is intentional or unintentional. Researchers need to be able to review these presuppositions in the light of their experience and try to picture the world differently in order to maintain their independence. However researchers are only human and when faced with a research question that touches on our own beliefs and values we can sometimes struggle to balance the competing roles of researcher and interested participant.

Reflexivity is a core concept in qualitative research and refers to one's attention to how power and bias come to bear during all phases of the research. Reflexivity is about the "politics of positionality" and acknowledging our power, privileges and biases throughout

the research process (Madison 2012). An awareness of the relationship and interaction between the researcher and the research environment (Lamb & Huttlinger 1989) allows the researcher to better understand how his or her presence and perspective influences the knowledge created. Put simply, reflexivity considers the reciprocal impact and influence the researcher has on that which is being researched. Reflexivity is crucial throughout all stages of the research study, including the formulation of a research question, data collection and analysis, and developing conclusions (Bradbury-Jones 2007).

Research demands scepticism, detachment and clear boundaries. This detachment derives in part from the assumption that the topic being studied is independent of and unaffected by the researcher. This is a challenge for the Professional Doctorate student, where the aim is to create and interpret new knowledge associated with your own professional practice. In the Professional Doctorate there is no clear boundary between outsider and insider for the researcher undertaking their own research in the professional setting (Burnard et al. 2018). Acknowledging this influence and its potential effects on my behaviour has facilitated greater self-scrutiny throughout the research process. Throughout this study I have tried to remain open minded and alert to my own biases, beliefs and pre-existing knowledge. To help with this I maintained an informal research journal where I recorded my thoughts, feelings, actions and reflections through the different stages of the research. This helped me to understand "what do I know" and "how do I know what I know". Looking back on my journal it is interesting to see how my views have changed as the study developed.

One of my main concerns at the outset of my studies was the potential for blurring of the boundaries between my role as a researcher and my role as Senior Inspector with Healthcare Improvement Scotland (HIS). HIS provides public assurance about the quality and safety of healthcare through the scrutiny of NHS hospitals and services in Scotland. I am a senior member of the management team at HIS leading on quality assurance and inspection of healthcare organisations, which involves regular interaction with the staff in the three healthcare organisations. I was worried whether my position at HIS could create an asymmetrical power imbalance and possibly influence the discussions and answers from research participants. Would they be open and honest? Would they tell me everything? I started by making it absolutely clear from the outset that this research project was

completely separate from my role in Healthcare Improvement Scotland. It was important to distinguish between a request from me as a researcher, which they can refuse, and a request from me in my professional role, which they cannot refuse. To further reassure the participants I emphasised that the research interviews were completely confidential and would not be shared with anyone else within the organisation. All information would be anonymised to maximise protection of participants' identities and at the same time maintain the value and integrity of the data. I did not feel at any time that the research participants were holding back or felt unable to express their views openly and honestly.

An awareness of my insider researcher status has also helped me to look past my own personal beliefs and mitigate the potential for my own biases in this research. Preconceptions brought about through an understanding and familiarity with the subject could have led me to over emphasise the benefits of social media in capturing patient experience. It is easy to be seduced by your own personal, prior believes and expectations. However I was alert to this and put in steps to minimise any bias, including interviewing a range of senior clinical and management professionals to ensure multiple views and experiences, ensuring that my interview questions were not steering particular responses, robust data analysis, and most importantly making sure to conclude only what the research results indicate.

Keeping up to date with a fast growing body of literature is an issue for research in any area, but it is been a particular challenge for me in undertaking research into the use of digital technologies. Social media are going through a rapid rate of growth and change, and new research is being published all the time. This was an ongoing challenge for me, not only from a personal view, but also because I was concerned that it could detract from the currency of the research contribution. However, by focusing on how the patient feedback is used alongside rather than on the social media tools, I believe I have managed to retain the currency of the research.

I found the critical analysis difficult at first and often took things at face value, repeating and summarising what was in the published literature rather than evaluating the argument and evidence. Over time I've learned to check the logic of the argument and examine any undeclared assumptions in the research. What is the point the author(s) is trying to make,

what is the basis for the argument and what methods have been used? I think a research student's best weapon is healthy scepticism, not cynicism, and a refusal to accept the conclusions of other writers without evaluating the arguments and evidence that they provide. It is not easy and I do not think I will ever be great at this but I understand the need for critical engagement with the literature, rather than a list of who said what.

The Professional Doctorate has definitely been a winding journey for me. Juggling a research degree with a professional career requires a lot of planning and an understanding family! At times it can be a solitary experience and has been as much a test of my personal resilience and persistence as it has been of my academic skills. However, it has been a hugely rewarding experience, which has stimulated intellectual, personal and professional development.

6. References

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Appendix 1

Invitation to Participate Letter

Dear Participant

You are being invited to take part in a research study that has received approval from University of Bath Research Ethics Approval Committee for Health and the Integrated Research Application System. The study is entitled

Healthcare organisations and the use of patient feedback captured through social media to improve the safety and quality of patient care.

The main aim of this Professional Doctorate in Health research study is to explore how healthcare providers might use patient feedback captured through social media to detect poor performance and identify areas for improvement.

Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the enclosed participant information sheet carefully and ask if there is anything that is not clear or if you would like more information.

Your participation is entirely voluntary and can only be conducted with your informed written consent. You are free to withdraw from the study at any time. The information you provide will be anonymous and confidential and cannot be linked back to you as an individual.

I sincerely hope that you will consider participating in this study. I will be contacting you by telephone in the near future to confirm your interest in being interviewed. If you have any questions concerning the study or require clarification of any points in the information sheet please feel free to contact me.

Thank you for considering this request.

Yours sincerely

Steven Wilson

Appendix 2

Participant Information Sheet

Healthcare organisations and the use of patient feedback captured through social media to improve the safety and quality of patient care

Researcher: Steven Wilson (steven.wilson@nhs.net)

Dear Participant

I would like to ask you to participate in an interview for a study on patient feedback and social media conducted as part of my Professional Doctorate in Health at University of Bath. The main aim of this study is to explore how healthcare providers might use patient feedback captured through social media to detect poor performance and identify areas for improvement.

Through this study I hope to better understand the following issues:

(i) Which methods are used by healthcare providers to capture and use patient feedback?
(ii) What are the enablers, barriers, advantages and disadvantages of using patient feedback captured through social media to identify opportunities for improvement?
(iii) How do these views vary between different professional groups?
(iv) How does patient feedback captured through social media augment, complement or contradict other sources of patient feedback?
(v) How do healthcare providers deal with any concerns regarding ethics, privacy and transparency concerning social media monitoring?

Participation in the study is entirely voluntary. It will involve an interview of approximately 60 minutes in length to take place by arrangement. You may decide not to answer any of the interview questions if you wish. You may also decide to withdraw from this study at any time by advising the researcher using the contact details at the end of this document. If you do withdraw from this study, all identifiable data will be destroyed. You will not be asked to provide a reason for withdrawing.

I may ask for clarification of issues raised in the interview some time after it has taken place, but you will not be obliged in any way to clarify or participate further.

The information you provide is confidential, except that with your permission anonymised quotes may be used. If you request confidentiality, beyond anonymised quotes, information you provide will be treated only as a source of background information, alongside literature based research and interviews with others.

The information gained from this interview will only be used for the above objectives. It will not be used for any other purpose and will not be recorded over and above what is required for the research.

Even though the study findings will be presented in conferences and published in peer-reviewed journals, only the researcher will have access to the interview data itself. There are no known or anticipated risks to you as a participant in this study.

If you have any questions regarding this study or would like additional information please contact

Steven Wilson

Senior Programme Manager

Healthcare Improvement Scotland

50 West Nile Street

Glasgow G1 2NP

Tel: 07989 546931

Email: steven.wilson@nhs.net

Thank you for taking part in this research and for sharing your experiences with us.

Appendix 3

Consent Form

Title of Project: Social Media Patient Feedback and Quality Improvement

Name of Researcher: Steven Wilson

Please initial each box

	I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.
	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason.
	I understand that some coded extracts from the interview may be used for the purposes of the research report and academic articles.
	I give my consent for quotations to be used in the report and research papers on the understanding that I will not be able to be identified by the use of these in any way.
	I agree to the interview being audio recorded
	I agree to take part in the above study.

_____

Name of participant

_____

Date

_____

Signature

Appendix 4

Semi-Structured Interview Guide

Senior Healthcare managers' perspectives of using social media patient feedback to improve care

Date	
Interviewee	
Institution	
Position	
Length of time in NHS	
Length of time in current post	

Introduction

Participation in the study is entirely voluntary. It will involve an interview of approximately 60 minutes in length and you may decide not to answer any of the interview questions if you wish. The information you provide is confidential, except that with your permission anonymised quotes may be used.

Key Areas to Cover

(i) Which methods are used to capture and use patient feedback?
(ii) What are the enablers, barriers, advantages and disadvantages of using patient feedback captured through social media to identify opportunities for improvement?
(iii) How do these views vary between different professional groups?
(iv) How does patient feedback captured through social media augment, complement or contradict other sources of patient feedback?
(v) How do healthcare providers deal with any concerns regarding ethics, privacy and transparency concerning social media monitoring?

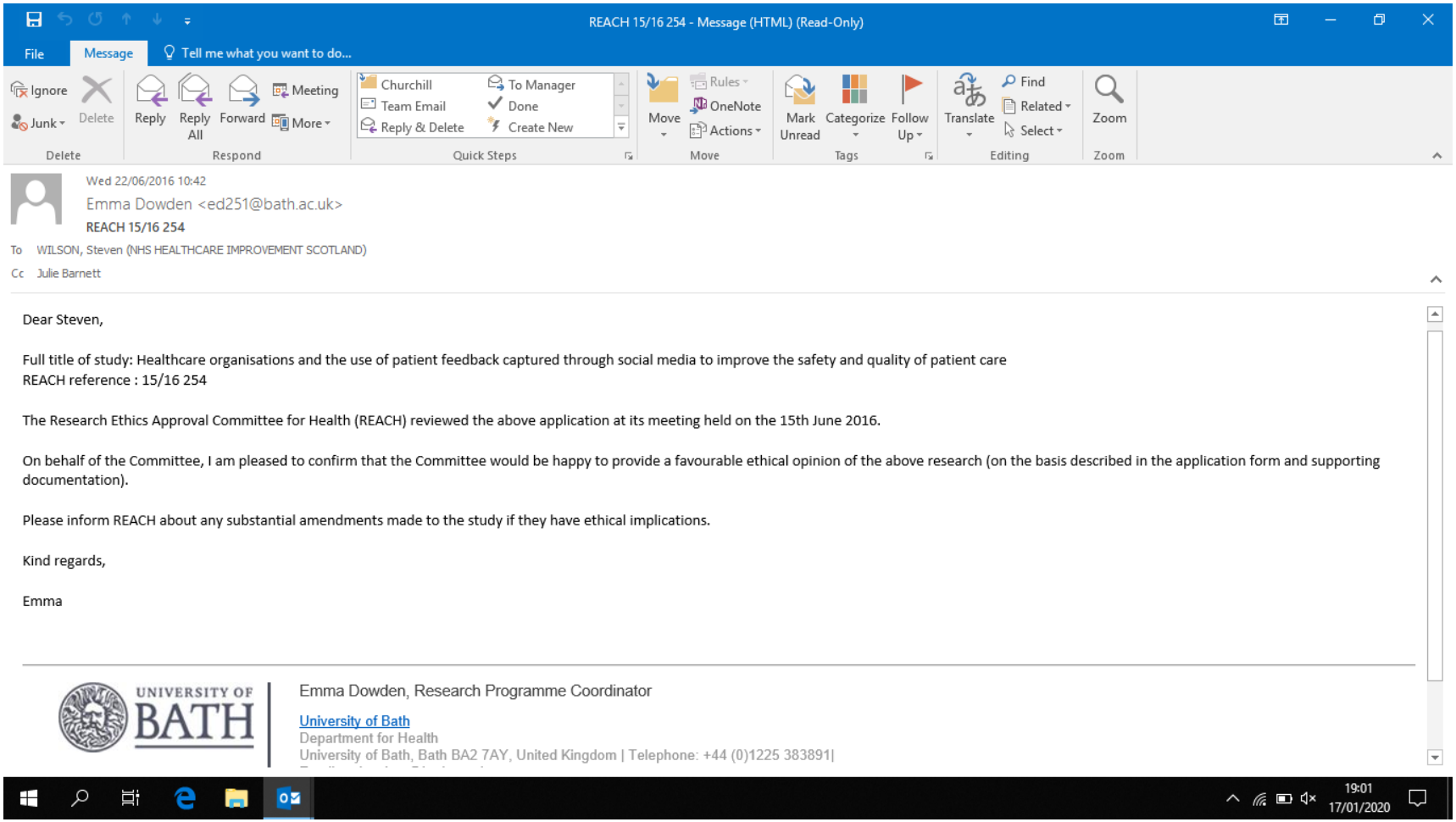
CONSTRUCT	QUESTION	Prompts
INTRODUCTION	• What does patient feedback mean to you?	Relational and functional aspects Improvement, accountability, learning Objective, subjective
METHODS OF COLLECTION	• Tell me about the methods you currently have in place to capture patient feedback	Surveys, Complaints, Compliments, Focus Groups, 1:1 Interviews, Mystery Shopper, Patient Panel Accessibility, Usability, Choice
USE OF PATIENT FEEDBACK	• What systems and processes are in place to understand and analyse patient feedback? • How does your organisation use and prioritise patient feedback data alongside other quality indicators?	Sharing the results of patient feedback Bottom Up / Top Down Learning Are staff empowered to respond to patient feedback

	• How does patient feedback flow upwards or downwards between the ward/team and the boardroom?	What would help wards/teams to respond to patient feedback?
SOCIAL MEDIA	• Who or what is driving the adoption of social media in your organisation?	Does your organisation have a social media policy? Does your organisation have guidance for social media use at the individual employee level? What social media platforms does your organisation use?
BARRIERS / ENABLERS	• What are the barriers and enablers to the use of social media feedback in your organisation? • Have any management challenges arisen as a result of implementing social media feedback in your organisation?	Resource or system pressures Organisational leadership Culture Limited co-ordination

	• How do you measure the impact and effectiveness of social media feedback in your organisation?	
SOCIAL MEDIA PATIENT FEEDBACK	• How does your organisation use social media to capture patient feedback? • What would you want to know, and why, before acting on social media patient feedback? • How might this information augment, complement or contradict existing sources of patient feedback? • What are the barriers to using social media patient feedback for quality improvement? • Do you perceive any ethical issues in using unsolicited comments from social media? • What impacts, both positive and negative, have you noticed as a result of using social media patient feedback?	Social media monitoring/listening Enablers, barriers, advantages & disadvantages Anonymity, bias, validity, small numbers, ability to rate professional skills Transparency v Confidentiality

SOCIAL MEDIA FEEDBACK AND QUALITY IMPROVEMENT	• How are you using social media feedback to inform and support service improvement? • How do you make social media patient experience feedback into actionable insights? • How could patient experience captured through social media be used to provide an early warning of quality issues? • Do you have examples of patient experience captured from social media being used to inform local quality improvement/patient safety activities? • How are teams supported to improve based on their patient feedback data?	Accountability Organisational learning Change processes Monitoring & evaluation Training & development
FINAL QUESTIONS	• What do you see as the future for social media and patient feedback • Is there anything else you want to tell me?	

Appendix 5


REACH 15/16 254 - Message (HTML) (Read-Only)
File
Message
Tell me what you want to do...
Ignore
Junk
Delete
Reply
Reply All
Forward
Meeting
More
Delete
Respond
Churchill
Team Email
Reply & Delete
To Manager
Done
Create New
Quick Steps
Move
Rules
OneNote
Actions
Move
Mark Unread
Categorize
Follow Up
Tags
Translate
Find
Related
Select
Editing
Zoom
Zoom
Wed 22/06/2016 10:42
Emma Dowden <ed251@bath.ac.uk>
REACH 15/16 254
To WILSON, Steven (NHS HEALTHCARE IMPROVEMENT SCOTLAND)
Cc Julie Barnett
Dear Steven,
Full title of study: Healthcare organisations and the use of patient feedback captured through social media to improve the safety and quality of patient care
REACH reference : 15/16 254
The Research Ethics Approval Committee for Health (REACH) reviewed the above application at its meeting held on the 15th June 2016.
On behalf of the Committee, I am pleased to confirm that the Committee would be happy to provide a favourable ethical opinion of the above research (on the basis described in the application form and supporting documentation).
Please inform REACH about any substantial amendments made to the study if they have ethical implications.
Kind regards,
Emma
UNIVERSITY OF BATH
Emma Dowden, Research Programme Coordinator
University of Bath
Department for Health
University of Bath, Bath BA2 7AY, United Kingdom | Telephone: +44 (0)1225 383891|
19:01
17/01/2020

Appendix 6

Research & Development

Mr Steven Wilson
Senior Programme Manager
Healthcare Improvement Scotland
Delta House
West Nile Street
Glasgow
G1 2NP

Date 23 August 2016
Your Ref
Our Ref

Enquiries to
Extension
Direct line
Fax
Email

Dear Mr Wilson

Healthcare organisations and the use of patient feedback captured through social media to improve the safety and quality of patient care

I confirm that [redacted] have reviewed the undernoted documents and grant R&D Management approval for the above study.

Documents received:

Document	Version	Date
IRAS R&D Form	5.3.1	11 July 2016
IRAS SSI Form	5.3.1	18 August 2016
Protocol	-	20 May 2016
Participant Invitation letter	1.0	22 June 2016
Consent Form	1.0	22 June 2016
Participant Information Sheet	1.0	22 June 2016

The terms of approval state that the investigator authorised to undertake this study within [redacted] is: -

- Mr Steven Wilson, Healthcare Improvement Scotland

With no additional investigators.

The sponsors for this study are Healthcare Improvement Scotland.

[redacted]

[redacted]

[redacted]

Mr Steven Wilson
Senior Programme Manager
Healthcare Improvement Scotland
Delta House
50 West Nile Street
GLASGOW
G1 2NP

R&D Department

[redacted]

Date 26.08.16
Enquiries to [redacted]

Direct Line
Email

Dear Mr Wilson

Project title: Healthcare organisations and the use of patient feedback captured through social media to improve the safety and quality of patient care

R&D ID: L16076

NRS ID Number: NRS16/194597

I am writing to you as Chief Investigator of the above study to advise that R&D Management approval has been granted for the conduct of your study within [redacted] as detailed below:

NAME	TITLE	ROLE	NHSL SITE TO WHICH APPROVAL APPLIES
[redacted]	Corporate R&D Manager	Local Collaborator	[redacted]

For the study to be carried out you are subject to the following conditions:

Conditions

- You are required to comply with Good Clinical Practice, Ethics Guidelines, Health & Safety Act 1999 and the Data Protection Act 1998.
- The research is carried out in accordance with the Scottish Executive's Research Governance Framework for Health and Community Care (copy available via the Chief Scientist Office website: http://www.cso.scot.nhs.uk/ or the Research & Development Intranet site: http://firstport2/staff-support/research-and-development/default.aspx

[redacted]

Date: 16 August 2016
Your Ref:
Our Ref:
Direct Line: [redacted]
Email: [redacted]
R&D ref: [redacted]

Mr Steven Wilson
45 Westerdale
Stewartfield
East Kilbride
G74 4JF

Dear Mr Wilson

Study title: Healthcare organisations and the use of patient feedback captured through social media to improve the safety and quality of patient care
[redacted]

I am pleased to confirm that I formally gave Management Approval to the study above on 16 August 2016. This approval is subject to the following conditions:

- A signed letter of access for yourself.

This approval is granted subject to your compliance with the following:

1. Any amendments to the protocol or research team must have Ethics Committee and R&D approval (as well as approval from any other relevant regulatory organisation) before they can be implemented. Please ensure that the R&D Office and (where appropriate) NRS are informed of any amendments as soon as you become aware of them.

2. You and any local Principal Investigator are responsible for ensuring that all members of the research team have the appropriate experience and training, including GCP training if required.

3. All those involved in the project will be required to work within accepted guidelines of health and safety and data protection principles, any other relevant statutory legislation, the Research Governance Framework for Health and Community Care and IHC-GCP guidelines. A copy of the Framework can be accessed via the Chief Scientist Office website at: http://www.cso.scot.nhs.uk/Publications/ResGov/Framework/RGFEdTwo.pdf
and ICH-GCP guidelines may be found at http://www.ich.org/LOB/media/MEDIA482.pdf

4. As custodian of the information collected during this project you are responsible for ensuring the security of all personal information collected in line with NHS Scotland IT security policies, until the destruction of this data.

5. You or the local Principal Investigator will be required to provide the following reports and information during the course of your study:

- A progress report **annually**

[redacted]

Appendix 7

Example Interview Transcript Notes and Coding

Codes			Notes
Reporting	I	I tend to look at the outputs and not worry myself about where the inputs are coming from. Online patient experience,	Reporting Patient Feedback
Engagement		Patient Opinion and all that I'm aware of but I don't deal much with it. What I am interested in is the graphs and the run charts and	Medical Director not engaged with online patient feedback
Reporting		knowing that Lanarkshire this month the aggregate score was 89% satisfaction rate. We haven't got that and it is a frustration we still haven't got that but that's really what I want to see. Then I want to see a breakdown	Quantifying and Aggregating Patient Feedback
Reporting		between my hospitals, community teams and see who is under the sort of 75% satisfaction. That's the kind of stuff I'm desperate to see.	Using Patient Feedback for Assurance Purposes & Comparison Between Sites
	S	Ok we'll pick up on some of that. So do you think patients are able to comment on both the interpersonal aspects as well as the functional aspects? I suppose that is like your core and surround	
Patient Feedback (Technical)	I	Oh they are but people probably wouldn't know a good technical operation has been performed but at the end of the day it could matter because of the side effects if it is poorly done. I remember in point where some poor women had a vulvar cancer and had a major operation where they used to do lymph node clearances and they had two surgeons doing lymph node clearance because it was such a long technical job. She complained because her left leg was swollen and the left leg being	Patients Unable to Feedback on the Technical/Clinical Aspects of their Care

Patient Feedback (Interpersonal) Patient Feedback (Expectations)		swollen was a sign that all lymph nodes had ben removed and that surgeon had done a better job than the other surgeon. So there is a case where a patient doesn't really know, but of course the patient should have been informed that this is what to expect and clearly she wasn't. Therefore found that this normal leg was the one she wanted rather than the swollen one! I think yes the patient can have a good idea of some of the technical success of things. At the end of the day it is how it affects them so a good other example would be around cataracts where it can be technically perfect but what the patient expects out of the operation is to see at night or to be able to see the golf ball from 250 yards. When they don't quite reach that they are disappointed because they were sold something that was probably never going to happen for them because they also had aged related macro degeneration. So the cataract operation helps a bit but it went from complete white out to something a bit better but it was never going to get…	Interpersonal/Humanistic Aspects of Patient Experience Patient Experience is based on their expectations Patients not just judging experience based on clinical outcomes
	S	So it is about managing expectations?	
	I	Yes, definitely	
	S	So what about what the challenges that we sometimes hear that patients are not able to be objective or their feedback can be subjective and mood-oriented?	
Patient Feedback (Expectations)	I	Yes it can be. First impressions sometimes can effect how people see things, or other people's prior	Patient Experience is influenced by a number of factors - expectations

Patient Feedback (Subjective)		experiences of family members or friends. So they can go in with a particular viewpoint, which then means we are destined to fail because they are looking for problems. Or illness anyway, people are depressed, tired. I think when people get feedback from patients you've got to understand it is not pure and accurate.	(met/unmet) and previous experiences Value of Patient Feedback Patient Feedback is subjective Not based on objective clinical measures Scepticism about validity